

**CREATING A MORE EFFICIENT
AND LEVEL PLAYING FIELD:
AUDIT AND APPEALS ISSUES IN MEDICARE**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION

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**CREATING A MORE EFFICIENT
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TUESDAY, APRIL 28, 2015

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:15 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Crapo, Thune, Wyden, Stabenow, Carper, Bennett, and Casey.

Also present: Republican Staff: Chris Campbell, Staff Director; Kimberly Brandt, Chief Healthcare Investigative Counsel; and Jill Wright, Detailee. Democratic Staff: Joshua Sheinkman, Staff Director; Jocelyn Moore, Deputy Staff Director; Matt Kazan, Health Policy Advisor; Elizabeth Jurinka, Chief Health Care Advisor; and Jennifer Phillips, Detailee.

**OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S.
SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The committee will come to order. Welcome to everyone.

Our hearing today will consider audit and appeals issues in Medicare. As some of you may recall, in July 2013 the Finance Committee held a hearing focused on audits of Medicare providers. At that time, Chairman Baucus and I were concerned about some of the stories we were hearing from hospitals, doctors, and others in the medical community.

That particular hearing gave us insight into some of the problems audits pose for providers. Now we turn to an issue that is directly tied to those audits, and that is Medicare appeals. I hear a lot about this whenever I go home to Utah, where Medicare issues remain a serious concern for my constituents.

For the past 2 years, like many members here, I continually hear about the terrible backlog of Medicare appeals. Before I move on to the appeals process in detail, I want to mention that improper Medicare payments continue to be a serious issue and a big part of the reason that we are seeing such a backlog in appeals.

Last month, the GAO released a report on government efficiency and effectiveness. The report found that in fiscal year 2014, Medicare covered health services for approximately 54 million elderly and disabled beneficiaries at a cost of \$603 billion. Of that figure,

an estimated \$60 billion, or approximately 10 percent, was improperly paid, totaling over \$1,000 in improper payments for every single Medicare beneficiary.

These numbers are unacceptable. This error rate must be lowered to ensure the viability of the Medicare trust fund so that Medicare can continue serving beneficiaries for years to come.

CMS has, of course, taken steps to identify and recover improper payments, including hiring contractors to conduct audits of the more than 1 billion claims submitted to the Medicare program every year. These auditors have recovered billions for the Medicare program, over \$3 billion in 2013 alone. However, the increase in audits has led to a seemingly insurmountable increase in appeals, with the current backlog at over 500,000 cases, evidenced by that particular chart there.

This increase in appeals has resulted in long delays for beneficiaries and providers alike. There are so many appeals that the Office of Medicare Hearings and Appeals cannot even docket them for 20 to 24 weeks. In fiscal year 2009, most appeals were processed within 94 days. In fiscal year 2015, it will take, on average, 547 days to process an appeal, far too long for beneficiaries to find out whether their medical services will be covered or for providers to find out if they will be paid.

Additionally, large portions of the initial payment determinations are reversed on appeal. The HHS Office of Inspector General reported that, of the 41,000 appeals that providers made to administrative law judges in fiscal year 2010, over 60 percent were partially or fully favorable to the defendant.

Such a high rate of reversals raises questions about how the initial decisions are being made and whether providers and beneficiaries are facing undue burdens on the front end. On the other hand, we need to recognize that ALJs have more flexibility in their decision-making than Medicare contractors do.

During the July 2013 hearing, we expressed our hope that CMS would consider the balance between program integrity and the administrative burden on providers. CMS has taken steps to show it is considering that balance. These steps include decreasing the burdens on providers, increased oversight of auditors, and more transparency in the programs.

When any Medicare contractor, either an auditor or a contractor that processes claims, decides that a claim should not be paid, it has a real effect on beneficiaries and providers, which is why it is so important that the appeals process allow these appeals to be heard in a timely and consistent fashion.

The Office of Medicare Hearings and Appeals has also taken steps to address its backlog, but there is only so much the agency can do with its current authorities and staffing. Senator Wyden and I, and the other members of this committee, are committed to finding ways to make the appeals process work more efficiently and effectively in order to ease the burden on beneficiaries and providers, and to protect the Medicare trust fund.

Today we have the opportunity to hear from those who are closest to the Medicare appeals process. I want to thank all of our witnesses for appearing here today to help us understand the issues that they face in dealing with the large number of Medicare ap-

peals. I do look forward to hearing their perspectives on how that process might be changed to create a more efficient and level playing field.

Let me turn now to my ranking member, Senator Wyden, for his remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Chairman, since the days when I was director at the home of the Oregon Gray Panthers, I have heard from seniors and their providers how frustrating it can be to deal with the arbitrary nature of the appeals process. Back in those days, everybody was in the dark. Essentially, nobody knew what the rules were, and there were no deadlines.

Now, some of those problems have been addressed. But today, the system is still broken, and that is the bottom line. There are new problems to confront, and today the backlog of cases is so large that the door to new appeals is essentially closed. New cases are no longer being heard.

So nobody is immune. Certainly not Oregon, where the problem of clogged appeals is tragically real, and it is something I hear about from seniors and their providers continually.

Now, we are going to hear a lot of statistics today. The numbers are big, and we are going to rattle them all off. The number of cases sent to the Office of Medicare Hearings and Appeals has soared from 60,000 to 654,000 over just a couple of years. We are talking about a tenfold increase in just a couple of years.

Now, one number that has not changed, and we ought to be talking about that as well, is the number of hearing officers handling cases. Today, about 60 hearing officers are available to hear these cases, and that was the case back in 2011. So it is no wonder that the appeals system is buckling under its own weight, and that the average time to process a claim is now 560 days.

So these are important references, and I just want, in closing, to say that, amid this blizzard of numbers and statistics, the real story is what happens to seniors as they try to navigate this system.

Here is a brief account of what happened to the late Stephen Lessler. Like many seniors, Mr. Lessler had hip surgery, and in 2013 he went to a nursing home for rehabilitation. About 1 month into his rehabilitation, Mr. Lessler was notified that his coverage under Medicare Advantage would soon stop. He was encouraged by the progress he was making, so he ultimately decided to pay out-of-pocket for another week. He also appealed the denial to Medicare.

The process went on and on and on. After losing earlier appeals, Mr. Lessler requested a hearing before an administrative law judge in December of 2013. Not until August of 2014—277 days later—did Mr. Lessler actually get a hearing. Eventually, he received a favorable ruling on September 24, 2014. Unfortunately, Mr. Lessler passed away the day before, September 23, 2014, at the age of 92.

It seems to me, the Senate has a duty to ensure that seniors receive the care that they are rightfully entitled to under Medicare. The Senate has a duty, as custodians of taxpayer dollars, to ensure those monies are spent in the best possible way. My view is that balancing these twin goals is going to take some fresh thinking.

Now, one idea is to allow less complicated and contested cases to be handled by a different set of hearings officers so that they can be processed more quickly. That would leave the more complicated and difficult cases to administrative law judges. Another idea would be to establish a refundable filing fee to prevent providers who gamed the system from crowding out those seniors whose cases need to be heard.

I want today's witnesses to give us their ideas for reforming Medicare's appeals process. I want to hear their thoughts on solving the problem and helping us creatively squeeze every drop of efficiency out of our current system. I do want to make clear that, with a tenfold increase in the number of cases, I believe that additional resources are going to be needed as well.

Efforts ought to be made to reduce the time it takes for an appeal to make its way through the system. Finally, what is needed is to prevent appeals from ever happening by getting it right in the first place.

So, Mr. Chairman, I look forward to working with you. This is an important hearing, and I think this is another area where there is an opportunity for creative and bipartisan approaches so that seniors get better and more prompt services and taxpayers' interests are represented as well.

The CHAIRMAN. Well, thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Before I introduce our witnesses—

Senator CARPER. Mr. Chairman? Mr. Chairman? Could I just be recognized for maybe 1 minute, please?

The CHAIRMAN. Yes.

OPENING STATEMENT OF HON. THOMAS R. CARPER, A U.S. SENATOR FROM DELAWARE

Senator CARPER. Thank you. I apologize. I appreciate the chance to say something. My thanks to both of you for bringing this important matter before the committee today. As the immediate past chairman of the Homeland Security and Governmental Affairs Committee, this is something we focus on a lot. We focus on improper payments.

GAO tells us that improper payments last year totaled \$125 billion, and more than a third of that is from Medicare. This is real money. This is real money that we are interested in. We need to save that money, as much of it as we can. We do not need to create undue headaches for providers of health care. So, this is important, trying to find the right balance. I am very, very grateful—I have a statement I would like to submit for the record, if I can.

We are having a mark-up on the Toxic Substance Control Act in the Environment and Public Works Committee, pretty contentious, and I need to be back there. We are going to try to find the sweet spot. I think we have, maybe, and can pass good legislation there.

We can hopefully find a sweet spot in this area as well. But thank you so much, and our thanks to the witnesses. My apologies. Thank you.

The CHAIRMAN. Thank you, Senator. Your statement will be placed in the record at the appropriate place. We are glad to have you here when we can.

[The prepared statement of Senator Carper appears in the appendix.]

The CHAIRMAN. Now, before I introduce the witnesses, it is my understanding that we have some special guests with us today. I would like to extend a warm welcome to the delegates from Afghanistan and Nepal who are joining us today. The Afghan delegation includes members of both houses of Afghanistan's national assembly. From Nepal, the delegation includes members of Nepal's constituent assembly.

The entire committee was deeply saddened to hear of the earthquake that struck Nepal on Saturday, and we do offer our condolences and our profound sympathy for all of those who have been affected. We certainly welcome you to this country, and to this hearing in particular, and hope you enjoy listening to these experts on this very important subject. We are grateful to have you here. We hope you enjoy your time while you are here in Washington, and especially in the U.S. Senate.

Now, turning to today's hearing, our first witness is Sandy Coston. Ms. Coston is the CEO and president of Diversified Service Options—we will call it Diversified—and its wholly owned subsidiaries, First Coast Service Options and Novitas.

First Coast and Novitas provide administrative services for processors for government-sponsored health care programs such as Medicare. In her role, Ms. Coston sets the strategy and vision and provides executive leadership for the Diversified enterprise. She has accountability for government contracts administration, including Parts A and B Medicare administrative contractor contracts, as well as managing a national provider reimbursement set of programs for undocumented alien emergency services and a financial management services contract for the national marketplace.

Our next witness is Tom Naughton. Mr. Naughton serves as senior vice president of MAXIMUS Federal Services, a subsidiary of MAXIMUS, Inc. that is dedicated to serving government agencies and programs. In that role, Mr. Naughton is responsible for the management and performance of MAXIMUS Federal's largest book of business: insurance benefit appeals and independent medical review services. His client base includes more than 48 State and Federal agencies.

Our last witness today is Judge Nancy J. Griswold. Judge Griswold was appointed Chief Administrative Law Judge for the Office of Medicare Hearings and Appeals on March 1, 2010. In this capacity, she oversees the third level of review for Medicare appeals within HHS and has responsibility for the second-largest administrative law judge corps in the Federal system.

In June of 1995, Judge Griswold began her Federal career as an ALJ in the Shreveport, LA Social Security Office of Hearings and Appeals. She served as the Hearing Office's Chief ALJ from 2002 until 2004, when she was appointed as acting, and then perma-

ment, Regional Chief Judge for the Boston region. She was then promoted to Deputy Chief ALJ at Social Security, where she served as alter-ego for the Chief ALJ and worked closely with him on the formulation of Social Security's extremely successful backlog elimination plan.

During her tenure as Deputy Chief ALJ, the Social Security Administration reached new levels of productivity and, I might add, prior to her departure had driven the backlog down for 14 successive months. She also had oversight of the ALJ hiring program at Social Security and recommended over 300 ALJs for appointment during her tenure. As Deputy Chief ALJ for Social Security, she assisted the Chief Judge in the management of over 8,000 employees, including 1,200 ALJs in 142 hearing offices.

So I want to thank you all for your willingness to come and be with us and to help us to understand these very important issues here, and I guess we will start with you, Ms. Coston.

**STATEMENT OF SANDY COSTON, CEO AND PRESIDENT,
DIVERSIFIED SERVICE OPTIONS, INC., JACKSONVILLE, FL**

Ms. COSTON. Thank you. Good morning, Chairman Hatch, Ranking Member Wyden, and distinguished members of the committee. It is my honor to be here today to testify before you.

As the chairman mentioned, we are a Medicare Part A and Part B administrative contractor, or a MAC, for 12 States and 3 U.S. territories, representing approximately 32 percent of the traditional Medicare program across our Nation.

The focus of my testimony today will be on ways to streamline the appeals process and to help in reducing the backlog, as previously mentioned. As a MAC contractor, one of the things that we do is we process the initial claims, and we also have accountability to process the first level of appeal.

When we receive appeal requests, we go through a process of triaging those requests and make a determination as to whether or not the appeal is valid. About 60 percent of the cases we receive actually turn out to be valid appeal requests.

The remaining 40 percent we handle administratively through either an inquiry response, or perhaps a clerical error reopening. This triage process is important so that we determine the appropriate course of action to take. The second through the fifth level of appeals are handled by other entities than us, and those are described in more detail in Exhibit 1 of my testimony.

I want to talk a little bit about what we have seen as a MAC contractor, and the genesis of the appeals backlog. Over the last several years, the number of entities that are involved in the evaluation of claims has increased dramatically, as has the number of claims being scrutinized. In addition to the MAC contractors, these entities include the Zone Program Integrity Contractors, the Comprehensive Error Rate Testing Program Contractors, and the Recovery Audit Contractors. Our experience has shown that the most significant contributor to the changes in the volumes of appeals has been the recovery auditor. Using First Coast Part A claims data as an example, the overall percentage of appeals driven by the recovery auditor decisions jumped from 7 percent in 2011 to 63 percent

in 2013. Similarly, the overall volume of appeals went from approximately 23,000 to 66,000.

To date, a number of actions have been taken by CMS and the Office of Medicare Hearings and Appeals to relieve that backlog that primarily exists at the third level, or the administrative law judge level.

We have several recommendations that may effectively reduce the backlog of appeals at the ALJ level and be able to keep the backlog down. First, we recommend that we remand cases to the prior level or the second level of appeal, which are processed by the Qualified Independent Contractor, when the ALJ finds good cause for the submission of new evidence. In cases when the new evidence is submitted at the ALJ level, remanding these cases back to the second level or to the QIC for handling would result in a reduction at the ALJ level and, ideally, quicker resolution for the provider. Further, handling these cases at an earlier level of appeal not only preserves the ALJ level for the provider when needed, but reduces the expense of having the MAC and the QIC prepare for and participate in cases that could have been resolved based upon the introduction of new evidence. Additionally, for the appeals that are favorable, there is a significant cost avoided by the ALJ and the provider, and likely the provider would receive payment sooner.

Our second recommendation is to establish a per-claim filing fee, as previously mentioned by the chairman. Our recommendation to streamline the appeals process would be to modify the work that the MAC does at the first level of appeal.

We would recommend that we retain that triaging process to make sure that we validate which are valid cases for appeal, and then we would also recommend that, for those appeals that are clinical in nature, they go directly to the second level while we retain just the administrative, non-medical-necessity appeals.

In eliminating this level of appeal of non-clinical appeals, we would also recommend that the funding be retained to further educate the provider community on how to appropriately address those claim denial findings that we see.

In closing, we appreciate the leadership of this committee, and we thank you for the opportunity to provide our point of view and look forward to questions that you may have.

The CHAIRMAN. Well, thank you.

[The prepared statement of Ms. Coston appears in the appendix.]

The CHAIRMAN. Mr. Naughton, we will take your testimony at this time.

**STATEMENT OF THOMAS NAUGHTON, SENIOR VICE
PRESIDENT, MAXIMUS FEDERAL SERVICES, INC., RESTON, VA**

Mr. NAUGHTON. Thank you, Committee Chairman Senator Hatch, Ranking Member Senator Wyden, and honorable members of the committee, for providing us the opportunity to discuss the Medicare appeal process and potential efficiencies and enhancements to that process.

Since 1989, MAXIMUS Federal Services and our affiliates have served as a Qualified Independent Contractor for the Centers for Medicare and Medicaid Services. In that role, we have completed

more than 2 million Medicare appeals across all parts of Medicare, addressing all forms of Medicare benefit and payment disputes.

Our QIC work is the hallmark of our largest market segment: independent benefit appeals and independent medical review. We are the largest provider of these services in the United States, and we currently serve more than 50 Federal and State agency clients.

I would note that MAXIMUS—and the company we are owned by, MAXIMUS, Inc.—is a government-only company. We do not provide any services or have any contracts with health care providers or health care payers. The independence is part of our mission, and it is a statutory requirement of our QIC contracts and Medicare contracts we administer throughout the United States.

Pursuant to section 1869 of the Social Security Act, a Qualified Independent Contractor is defined as “an entity or an organization that is independent of any organization under contract with the Secretary that makes initial determinations.” The organizations encompassed within the meaning of section 1869 include, but are not limited to, Medicare Administrative Contractors, Zone Program Integrity Contractors, Recovery Audit Contractors, and Quality Improvement Organizations.

The primary goals of the QIC program are timely adjudication of reconsiderations—that would be the level two of appeal; case management of those appeals within the Medicare appeals system; and assuring timely and appropriate communication to the first level of appeal at the MACs or, on the Part C and the Part D side, Medicare Advantage plans and Medicare drug plans, as well as communicating with the ALJs at the third level of appeal.

Similar to all stakeholders within this appeal process, within recent years the QICs have experienced unprecedented volumes. Nowhere was this more evident than in our Part A program, where, if you look at the chart here, you can see volumes growing exponentially over just a few-year period.

Just as an example, in February 2010, we received a total of 4,900 appeals. In February of 2012, we received a total of 12,000 appeals—just in the month of February—for that Part A program, which is an increase of 159 percent. In February 2015, we received 45,000 appeals, an increase of 253 percent over 2012 and an increase of 815 percent in the prior 2-year period.

This influx of appeals created a backlog and created significant issues for our infrastructure, and we were forced to act quickly to address this backlog and to ensure that these appeals were adjudicated as quickly and as appropriately as possible. We accomplished that through technology, through adding resources. You can see that we went from fewer than 30 clinical staff in the Part A program to over 140 in that Part A program. But more importantly, we changed our processes and created specialized teams to address specific appeals.

This change in process led to an end to the backlog which began in the spring of 2013 and was cleared by the fall of 2013. And with the change in this technology, additional staff, and processes, we have been able to avoid further backlogs since 2013.

Based on those lessons learned, we have a number of recommendations which we think will continue to help the appeals program

evolve and provide more efficient services to beneficiaries, providers, and all stakeholders.

I think the number-one issue for the current backlog would be to create a support unit for the ALJs. This was an idea that was considered back in 2004 prior to the ALJs coming to OMHA in 2005, in which attorneys, nurses, physicians, certified coding specialists, other subject matter experts would provide support to the ALJs and help them make decisions and adjudicate the claims in a more timely fashion.

I think in this issue, as was mentioned by Chairman Hatch, taking the less complicated appeals and having subject matter experts address those appeals for the ALJs would help address the backlog quickly. I also think creating a Recovery Audit Contractor-only QIC, so that a QIC specializes in audit contractor appeals, would help educate the program, assist all the stakeholders in adjudicating those appeals, and give us a centralized resource to understand exactly what is going on with the audit contractors and at all levels of appeals.

I also agree with all of the recommendations of Ms. Coston. I think other recommendations would be to change audit contractor pricing to a per-case review, or to a more definitive cost, and do away with contingency pricing. That seems to cause concern for stakeholders, and I think there are ways to pay the audit contractors other than through contingency pricing.

I think enhancing the scope of work for the Administrative QIC to provide greater education to all stakeholders would be helpful, and I also think, if we do not provide support to the ALJs through providing subject matter expertise, allowing the QICs to participate in a greater percentage of hearings would be helpful for adjudicating those hearings and getting a more consistent decision for those hearings.

Just as an example, in 2014 we participated in less than 5 percent of Part A hearings. The uphold rate for our decisions in which we participated was 66 percent, and, in hearings where we did not participate, the uphold rate was 37 percent—obviously a large difference between when we are participating and not participating.

I look forward to having further discussions on these potential efficiencies and enhancements, and thank you again for your time.

The CHAIRMAN. Well, thank you.

[The prepared statement of Mr. Naughton appears in the appendix.]

The CHAIRMAN. Judge Griswold, we will turn to you to wrap up here.

STATEMENT OF HON. NANCY J. GRISWOLD, CHIEF ADMINISTRATIVE LAW JUDGE, OFFICE OF MEDICARE HEARINGS AND APPEALS, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Judge GRISWOLD. Chairman Hatch, Ranking Member Wyden, distinguished members of the committee, it is my honor to be with you today to discuss proposals for creating a more efficient process for Medicare appeals.

Chairman Hatch, I want to thank you and Senator Wyden and your staffs for your interest in resolving the challenges that are

being faced by the Medicare appeals process. I also want to thank Secretary Burwell for her commitment to restoring the balance between the Department's audit efforts and its responsibility to provide a high-quality and timely appeals process.

Three separate agencies within HHS are charged with administering the Medicare appeals process, with OMHA being generally responsible for the third level of review. OMHA was established in June of 2005 with the goal of reducing the then-average 368-day waiting time for a decision to the 90-day time frame established in the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000.

In order to make certain that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency reporting directly to the Secretary, having a second appropriation, and operating, both functionally and fiscally, separately from CMS.

We are grateful for the enacted funding increases in fiscal years 2014 and 2015 which have allowed for the hiring of 12 additional ALJ teams and the opening of a fifth field office. However, even this additional capacity pales in comparison to our incoming adjudication workload. In fiscal year 2013 alone, OMHA received over 384,000 appeals and, in fiscal year 2014, approximately 474,000 appeals. Although ALJ teams more than doubled their disposition capacity from fiscal year 2009 through fiscal year 2013, they have not been able to keep pace with receipt levels, and adjudication times have now increased to 572 days.

Several reasons for the increase in appeals can be identified. In fiscal year 2010, OMHA began to take on new workloads, including appeals resulting from the nationwide implementation of the Recovery Audit Program. There have also been increases in appeals filed by Medicare State agencies and in OMHA's traditional workload. Finally, Medicare enrollment has grown as the baby boom generation becomes Medicare-eligible and as younger individuals have been added to the disability rolls and become eligible for Medicare benefits as well.

In response to this record growth, OMHA has taken a number of administrative actions, most significantly through ongoing development of an electronic case processing system and standardized business process. We have also enhanced our adjudication training programs. As part of its Settlement Conference Facilitation Pilot, OMHA has resolved over 1,000 appeals, which represents the average productivity of an entire ALJ team working for a full year.

The President's 2016 budget request would increase OMHA's current budget from \$87.3 to \$270 million and would allow us to add 119 new ALJ teams and 82 Medicare magistrates, increasing adjudication capacity from 77,000 to approximately 278,000 appeals per year. The President's budget also proposes seven legislative reforms: expanding the Secretary's authority to retain a portion of recoveries from the Recovery Audit Program to fund the related appeals process at OMHA; establishing at the fourth level, the Departmental Appeals Board, a refundable per-claim filing fee; allowing sampling and consolidation of similar claims without appellant consent; requiring remand of appeals upon introduction of new evidence; increasing the minimum amount in controversy required for

adjudication by an ALJ to the amount required for judicial review; establishing a Medicare magistrate program for appeals falling between the current amount in controversy and the new amount required for an ALJ hearing; and finally, providing for resolution of appeals having no material fact in dispute when the decision is governed by a binding authority.

OMHA is privileged to have a dedicated and innovative workforce of ALJs and staff, who are committed to processing Medicare appeals that are both timely and reflect the highest quality of decision-making. However, administrative initiatives alone are insufficient to close the gap between workload and resources at OMHA.

The Department believes that the funding and legislative proposals contained in the 2016 President's budget will begin to close this existing resource gap, and I look forward to our dialogue on these issues today. Thank you.

[The prepared statement of Judge Griswold appears in the appendix.]

The CHAIRMAN. We appreciate all three of you and the hard work that you are doing. We are naturally very interested in what you are doing. Your organizations really are very important to our society, especially as they process these appeals quickly and efficiently.

Now, as I mentioned before, the backlog of appeals has real monetary implications for beneficiaries and basically everybody else, including our government. The beneficiaries and providers are both very concerned, and my colleagues and I are concerned about it as well.

Now, each of you represents a different level of the appeals process. We understand that handling a large volume of appeals is a daunting task, and the American people place a great deal of trust in you, and of course your important work.

My colleagues on this committee and I are committed to improving this system, and there are, in our opinion, a wide variety of approaches that must work in tandem if the process is to be reformed.

I would like to ask each of you to explain your organization's role in the appeals process and your biggest challenge. You have basically explained your role, but give us the biggest challenge in fulfilling your role as you see it. We can start with you, Judge. Why don't we just go across?

Judge GRISWOLD. Well, we are an ALJ organization, administrative law judges, and our judges hold hearings in accordance with the Administrative Procedure Act. I think our biggest challenge right now is to handle the incoming workload. We are keenly aware of the impact that these delays are having upon our stakeholders, the people who file appeals before us.

So, if I could expand to two challenges, I think one is to go to a fully electronic system. We are in that process right now, and that will gain us some efficiencies, but it is a multi-year project. Then the second would be just simply our capacity to handle the incoming receipts.

The CHAIRMAN. Well, thank you.

Ms. Coston?

Ms. COSTON. Thank you. I would describe our biggest challenge as beginning with the processing of the claims. We receive a significant portion, probably the high 90th percentile of claims, electronically. Those claims process through CMS's standard systems. There is a separate Part A and a Part B system. They process through that system, and we touch about 5 percent of those claims, so about 95 percent process automatically.

There are edits and audits within the system that, if claims meet certain criteria, they will suspend for manual intervention, but we do not receive medical records on the front end to be able to process those claims. So I know, Mr. Chairman, when you talked about the overturn rate, one of the challenges that we have is that we adjudicate claims without medical records.

So, when we ultimately would deny a claim and it is appealed, that is really the first look we get at the medical record behind that claim, unless of course we have a provider that is on pre-payment review—and we do have providers that are on pre-payment review based on data analytics. If they show aberrant behaviors, we will put them on pre-payment review.

But I think really just understanding that the process by which we are held accountable—we do not really see that medical documentation until that appeal is filed, so it is really about education to the provider community to make sure that they are appropriately documenting that medical record. So often, the improper payment rate that you have referred to, is driven by lack of appropriate documentation.

It is not that we are necessarily challenging that the services were medically necessary, it is that the providers are not adequately documenting that in the medical record. Thus, part of our recommendation is to increase the level of education to make sure those claims are appropriately documented so that, when they are denied, upon appeal we can see in the medical record that they were in fact medically necessary.

The CHAIRMAN. Well, thank you.

Mr. Naughton, let me just ask you this question. I could say to each of you, you could answer this question: providers report that the use of different appeals numbers at various levels of appeal is confusing and does hamper efficient tracking. Might you all consider implementing a uniform docketing system across various levels of appeal? I just would like—what do you think about that, Mr. Naughton?

Mr. NAUGHTON. Well, we would consider that, and I think we recommended that previously. One of the largest process issues for all stakeholders—and it has been referred to by Ms. Coston and Judge Griswold—is that there is not full electronic communication between all levels of appeal.

Currently, we may be receiving electronic records. We then download them, print them, box them up and send them to the ALJ. If we were able to create a centralized database and a system for all parties to the appeal process, first of all, we would all know what the full record is.

There would be no dispute of what the entire record is, and we would have access to that, and it would provide much greater transparency and visibility to providers to understand where their

case file is, when it is expected to move, and what are the documents associated with that case file.

The CHAIRMAN. Well, my time is up, but, Judge Griswold, it seems to me that the judges could standardize case administration so there is a uniform system of hearing instructions and processes. So, you might take that under consideration and see if you could recommend how to resolve that particular problem.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I also want to extend our condolences to our delegation from Nepal. I believe they are in the audience now. We are glad you are here, and we look forward to talking with all of you about issues and a happier time for your country.

Let me start with you, Judge Griswold. I want to start with what I described in my opening statement, which is what this really means for seniors. The Center for Medicare Advocacy is one of our most influential and prestigious organizations advocating for the rights of seniors. They filed a class action, as I think you know, requesting relief for all of the seniors who have been up against these interminable delays.

Mr. Lessler, the case that I mentioned, was one of those in the class. As you know, Mr. Lessler essentially got a refund after he died. He had been in the system, just kind of bouncing around in the system, for what was an interminable period.

So to me, what this is really all about is not just these statistics and legalistic terms about various kinds of procedures, but the bottom line for me is, how do you keep that from happening again?

So, I think what I would like to do is have you start and tell us what might help generate the kind of urgency that it is going to take in a challenging Congress to actually get this done. Because to me, to hear a story like Mr. Lessler's, where everybody says, "gee, that is awful," and then everybody kind of goes about their business, reading position papers and the like, that is not what this is about. This is about keeping this from happening again. What do you think is necessary to do that?

Judge GRISWOLD. Well, at the Office of Medicare Hearings and Appeals, we definitely feel the urgency, because we are dealing with this pending level, which now comes in right at about 870,000 pending appeals at our level. So we definitely feel that. I think that what you are talking about, though, when you take those numbers and you start translating them into real-life stories and real-life impacts, I think that is what is needed.

Senator WYDEN. So what is needed to keep it from happening again?

Judge GRISWOLD. I think that we need to look at two pieces of it. One is dealing with the number of receipts that are coming in the door. There are a number of things that could be done on that end. The filing fee. This proposal for a refundable filing fee is one of those proposals that would impact the number of cases coming in.

We have found that in 2015, 51 percent of our incoming appeals had been filed by 5 appellants. So I think the filing fee would encourage appellants to take a closer look at what they are appealing and to be a little more discriminating in what they bring before us.

Senator WYDEN. I think that last point is an important one to note. The Inspector General found that essentially this very small number of providers account for a very substantial number of the appeals.

For you, Ms. Coston, and you, Mr. Naughton, your general finding is that a small number of providers are essentially the challenge. So what we ought to do is really laser in, in terms of tracking those people, monitoring those people, and watchdogging that population. Do you share that view, Ms. Coston?

Ms. COSTON. I do not think we see that so much at the first level. But to add to Judge Griswold's comments on your prior question, one thing that we see is there is—at the different levels, new evidence can be introduced.

So, when we make a determination on the first level of appeal, we might not have as much information as the ALJ does when the appeal goes to their level. So one thing that we would recommend is that all evidence be introduced at the first level of appeal, and then perhaps we can resolve these appeals much sooner without escalating to the higher levels.

Senator WYDEN. That sounds logical. Maybe it is too much for Washington, but it certainly sounds logical to me.

The Inspector General's report says that providers who have the resources almost automatically appeal. They just automatically appeal because they have a good shot at getting a favorable decision and getting people to settle. Is that something that you have found, Mr. Naughton, this process of sort of figuring you can beat the odds?

Mr. NAUGHTON. Yes.

Senator WYDEN. You automatically appeal? Just do it sort of by rote and figure you can win?

Mr. NAUGHTON. So, a couple points. In most appeal programs, it is usually a 20/80 problem, where 20 percent of the population is 80 percent of the appeals. I think in the audit contractor world, it is even greater than that, and I would agree that 5 percent is probably responsible for the majority of all appeals.

I would also agree that these providers with resources—we know for a fact they are engaging high-powered law firms to represent them at ALJ hearings where the ALJs may have no support or no one is representing the other side of the story. And certainly they know, if we continue to appeal this, our odds of our winning are greater because we have the resources to get behind this and make sure we win it.

Senator WYDEN. Well, we are going to follow up with you on this, because my point is that the vast majority of providers are honest and straightforward in terms of their dealings with patients and taxpayer dollars. But clearly there is a small number that has figured out a way to really hotwire the system, to just game it and, like you say, play the odds. I think Ms. Coston's point about trying to get the evidence earlier in the process strikes me as sensible.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman and Mr. Ranking Member. Welcome to all of you. Let me just first say

that Medicare is an incredibly important health care system, and has been since it was enacted in 1965. We want to make sure that it continues to be affordable and comprehensive and that it is a guaranteed program.

I do have to say that, as we are getting ready to see the final budget come forward from the conference committee between the House and the Senate, I am very, very concerned about the billions of dollars being cut in that budget resolution, which is a broader discussion beyond today. But for the record, I continue to be very concerned about the cuts to Medicare and the attacks on the guaranteed system of Medicare. But it is incredibly important that we address fraud and abuse and that we are able to have a system with integrity, which is what all of you are talking about.

So, a couple of questions. It is very important that we have a system that works, that is timely. My question relates to how we get ahead of this on the front end. We have a system, the Recovery Audit Program, that holds potential to do that. However, the high likelihood that appeals are found in favor of the provider on the one hand, not the auditor, suggests that we need updating. So the cases are being brought, but then the appeals are being filed and then the majority of the appeals, as I understand it, are found in favor of the provider.

So on the one hand, we need oversight, and on the other hand, we need to make sure we have quality health care. So, when you think about the appeals backlog and the dollars spent in this whole process, I am wondering if each of you can suggest some ways on the front end to ensure that providers understand the evolving payment procedures, have clear expectations on the front end, and then second, Ms. Coston, you spoke about—and any of you can talk about this—the Recovery Audit Contractors. I realize none of you is in that end of things, but you mentioned the claims going from 7 percent to 63 percent.

Again, on the front end, as we look at how to get ahead of this, I am very concerned and really question at this point—that system is on a contingency basis, so each claim that is denied and money that is clawed back, then, as I understand it, funds the system, funds the audits, the auditors.

So I am concerned that if the hospitals are bearing the full cost of appealing the auditors' findings, I do not know of any consequences on the auditors' end for those outcomes. So if a majority of them end up siding with the provider, but yet the incentive is to deny the claim in that piece of it, it seems to me like we ought to be focused on some changes and getting this right on the front end.

So on the front end, I guess I would ask each of you—first, Ms. Coston, since I mentioned your comments—what should we be doing on the front end? Do we have the incentives, at least for part of this, in the wrong place? What should we be doing working with providers on the front end?

Ms. COSTON. Sure. Sure. Well, and to reiterate, I think there can be more education with the provider community to help them understand how to document that record and file the claim correctly the first time. So I think that is number one.

Number two, as I mentioned, to be able to require the provider to submit all evidence at the first level of appeal would be helpful. I think that CMS has made some strides with the recovery auditors in terms of, there was a moratorium for a while because the recovery auditors were focused primarily on Part A claims, which are the very high-dollar claims, and that is where we saw the significant spike on the Part A side in that time period that I mentioned, because it was financially advantageous for the recovery auditors to focus on the Part A claims.

CMS has also instituted the limit on the number of claims that the recovery auditors can look at, and they have to vet the services that they want to look at with the agency ahead of time. So I think there have been some things that have been implemented to try to reduce that heavy burden of those Part A appeals.

Senator STABENOW. Let me just ask, if I might interrupt in the interest of time, do you think it makes sense that the Recovery Audit Contractors are paid on a contingency basis for each claim they deny? Is that the right incentive?

Ms. COSTON. That payment system has actually been changed—

Senator STABENOW. It has been?

Ms. COSTON [continuing]. So that if indeed there ultimately ends up being an overturn of the recovery auditors' decision, that fee is no longer available to them. So initially, when the Recovery Audit Program was rolled out, they retained the contingent fee no matter what, but that has changed.

Senator STABENOW. Does anyone else want to comment? I know my time is up.

Mr. NAUGHTON. I do think on the front end, again as I mentioned in my testimony, putting an end to the contingency payment can be done. It can be determined. We believe there is \$500 million out there for you to get. If you get \$500 million, we will pay you \$50 million. If you do not reach that, you will get paid less; if you get more, you will be paid more. So there are ways to pay them outside of contingency on a per-claim basis.

All QIC appeal programs are on a per-claim basis, so I think that is something that can be considered and is a possibility. I think at the level two, greater outreach, education to the providers, greater transparency of what is going on with the appeals to the providers, and providing providers the resources they need to understand what is going on with their appeal and the reasons for the denials, will help educate and prevent a high level of appeals going forward.

Senator STABENOW. Thank you. I realize my time is up, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Casey?

Senator CASEY. Thank you, Mr. Chairman. I appreciate the hearing, and I want to thank our witnesses for being here.

Judge, I want to start with you. We know from the testimony today and from all of the evidence that is presented that this is a system that is stressed. That might be an understatement. We also know that the funding here is in the discretionary category and that the President's budget has included a proposal to access funds recovered by the so-called Recovery Audit Contractors.

I guess the main question I have is one of resources. I think the operative word would be "additional." What additional resources would allow you to operate more efficiently and process appeals more efficiently?

Judge GRISWOLD. Well, the \$270 million which is in the President's budget would allow us to hire 119 ALJ teams, which essentially means 119,000 additional appeal dispositions per year. In coordination with other legislative proposals, we would also look at hiring magistrates, which would essentially be like a small claims court. These are individuals who would be less costly for us in terms of their team support, but they would be processing right at that same number. We project about 1,000 appeals per magistrate. They would be handling appeals that would fall between the current amount in controversy, which is \$150, and the Federal court limit, which is right now \$1,460.

Our thought with this is that the ALJ is really the one who prepares a record that is prepared in accordance with the APA and that is suitable for going to Federal district court. If the claim or if the case cannot get to Federal district court because of the amount in controversy, it makes sense to have that adjudication done by a less-costly official. So we think that with that combination of adjudicators, additional ALJs, and the Medicare magistrates, we would be able to up our disposition capacity from 77,000 per year, roughly, to 278,000 per year.

Senator CASEY. Say that last number again.

Judge GRISWOLD. Two hundred and seventy-eight thousand appeals per year.

Senator CASEY. From?

Judge GRISWOLD. From 77,000.

Senator CASEY. Seventy-seven? All right.

Judge GRISWOLD. Right. Because we currently have 77,000, or will May 3rd. We have five new judges reporting May 3rd, and so we will have a capacity of 77,000 per year, given the current budget.

Senator CASEY. I appreciate that. I realize this is ground you already may have been plowing, as I was in and out today, but I am a great believer that resources matter, especially when you can very specifically focus on what resources would be used for. You can make the nexus as, I think, taxpayers have a right to expect, that we can make the case or the connection between an expenditure, the hiring of more judges, or the investment of greater resources—

We have a similar problem in other parts of the Federal Government. We have, for example, black lung cases. This is the perfect storm: case numbers going up; the number of administrative law judges going down. That is a recipe for major problems.

I guess in the remaining time, I have just one kind of broad question, if it is possible for any one of the three of you, or more than one, to kind of walk through an example of an appeal as it winds its way through the process and kind of the time line, if you can do that.

You may have already done it with regard to your testimony, but just kind of, what is the typical case, especially in terms of time line, and why is that emblematic of, or an example of, what the

problem is? Does that make sense? You have 16 seconds. [Laughter.]

Ms. COSTON. So we are the first level of appeals, as I believe I had mentioned earlier. Currently, I would say generally we are processing appeals timely. We are at the workloads that we expect. We have 60 days to process appeal cases. After the claim is processed, the appellant has 120 days to file that appeal. So depending on how long they take, we are generally processing within the 60-day time frame.

Mr. NAUGHTON. And we are the second level of appeal, and our time frames, depending on the case type, can be 72-hour expedited, 30-day pre-service appeal, or a 60 calendar-day retrospective appeal. At our level of appeal, all cases involving medical necessity are reviewed by a physician, which is different from some of the other levels of appeal. When we have completed our part, we can move to the ALJ.

Senator CASEY. Great. Well, thanks very much. I know we are out of time.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you. I want to thank our witnesses for appearing here today. I also want to thank the Senators who were able to participate, given our busy day today. It is one of the worst busy days we have had around here.

This is an important issue, but the committee needs to give some thoughtful consideration to it in terms of legislative solutions. I do appreciate all three of you and your participation here today.

Any questions for the record should be submitted no later than Tuesday, May 5th.

With that, we will put the committee into recess. Thanks so much for being here. I appreciate you.

[Whereupon, at 11:16 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. THOMAS R. CARPER,
A U.S. SENATOR FROM DELAWARE

Without doubt, we must ensure that Medicare continues to provide critical care to our nation's seniors and at the same time finds ways to contain the growth of health care costs. I believe we can do both. And one critical approach for an effective, and cost-effective, Medicare program is to have appropriate and smart oversight and auditing.

We need to make sure that taxpayer dollars are spent on appropriate health care services that are needed by Medicare beneficiaries. The Government Accountability Office estimates that almost \$46 billion of the Medicare fee-for-service expenditures were lost due to improper payments in the last fiscal year. Unfortunately, that level has been increasing during the past few years.

Medicare oversight and audits are conducted by a number of different types of oversight contractors working for the Centers for Medicare and Medicaid Services (CMS). Not surprising, the alphabet soup of oversight can be confusing to anyone. My staff has heard complaints regarding reviews of Medicare claims conducted by each type of audit, and the ongoing and understandable confusion about which auditor is looking at a claim. In addition, I have heard from Delaware hospitals about the financial burdens placed on health care providers from the oversight of Medicare claims by CMS and its audit contractors. Clearly, we can do a better job to identify unnecessary and ineffective oversight steps that put a burden on doctors, hospitals and other providers, and make sure CMS has a better process to help providers make their way through the maze of audits and rules.

Furthermore, a key element of the Medicare auditing programs is to *prevent* overpayments before they are made. When a consistent error or payment vulnerability is identified by the auditing contractors, Medicare officials are supposed to keep track of the problem. CMS is then supposed to address the problem, by either changing how payments are approved and reviewed, or by communicating a solution or clarification to the health care provider community. However, I understand that a change in law is needed to allow some of the Medicare overpayment recoveries to be used for this outreach, which of course would help prevent future overpayment and reduce the burden on providers.

As the Members of the Senate Finance Committee are well aware, the Medicare “doc fix” legislation—also known as the Medicare Access and CHIP Reauthorization Act—was enacted earlier this month. The legislation included some very good improvements to program integrity, including how CMS and its contractors reach out to health care providers to ensure a strong understanding of Medicare payment rules. I was also happy that the “doc fix” legislation included some important provisions of a bill I introduced this year, called the *Preventing and Reducing Improper Medicare and Medicaid Expenditures Act*, that consists of a range of steps to prevent waste and fraud. However, one provision of my legislation that did not make it into the new “doc fix” law would have provided more resources for Medicare provider outreach and education. I hope to find other avenues to provide these resources.

From the testimony of the witnesses, and from past hearings of the Committee, I think there are a lot of straightforward and helpful steps to improve the Medicare audit rules and procedures. I am committed to working with the committee, the administration and the many stakeholders to improve how audits are performed.

PREPARED STATEMENT OF SANDY COSTON, CEO AND PRESIDENT,
DIVERSIFIED SERVICE OPTIONS, INC.

Chairman Hatch, Ranking Member Wyden, and distinguished members of the Committee, it is an honor to testify before you today. I am Sandy Coston, CEO and President of Diversified Service Options, Inc. (Diversified) and its wholly owned subsidiaries, First Coast Service Options, Inc. (First Coast) and Novitas Solutions, Inc. (Novitas). With over 20 years of experience in the Medicare program, I am very grateful for the opportunity to share my thoughts on how to improve the Medicare appeals process.

First Coast and Novitas contract with the Centers for Medicare and Medicaid Services (CMS) to provide quality Medicare administrative services throughout the United States to approximately five hundred thousand health care providers who care for more than eleven million Medicare beneficiaries. The services we provide include claims processing, customer service, appeals adjudication, education and outreach activities, and functions that help ensure the integrity of Medicare Program payments.

We are proud to serve as the Part A and Part B Medicare Administrative Contractor (MAC) for Florida, Puerto Rico, and U.S. Virgin Islands (Jurisdiction N), Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania (Jurisdiction L), and Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma and Texas (Jurisdiction H). Collectively, these three contracts represent approximately 32% of the national Part A and Part B Medicare workload. We take our responsibility of protecting the Medicare Trust Fund seriously and we have approximately 3,400 staff located in Florida, Georgia, Maryland, Pennsylvania, Texas, and Wisconsin that carry out these responsibilities on a daily basis. Our headquarters are in Florida and Pennsylvania and we have proudly served the Medicare Program since its inception.

We applaud the Committee for holding this hearing to highlight the need to improve appeals processes. We also appreciate the work of Senator Hatch and Senator Wyden for their work focusing attention on making improvements with input from Medicare contractors such as ours and other key stakeholders who care about the Medicare program and are committed to making improvements.

The focus of my testimony today will be on ways to streamline the appeals process and lower the appeals backlog; specifically, our role in the appeals process, a description of what we believe generated significant increases in appeals resulting in the current backlogs, efforts that currently take place to alleviate these backlogs, and provide our expertise on additional recommendations to improve the process and further reduce additional appeals backlogs.

CURRENT APPEALS PROCESS

Medicare claims are submitted to a MAC for processing. Approximately 95% of Medicare Part A and Part B claims are processed by CMS claims systems without human intervention. Should the claim determination result in a decision that differs from the expectation of the physician, provider, supplier or beneficiary, they have a right to appeal the decision. Currently there are five different levels of appeal.

As referenced in the attached Exhibit I—Claims Appeal Process, the MAC handles the first level of appeal, also referred to as a redetermination. When submitted within the 120 day time limit, the MAC reviews both its initial claim determination as well as any and all information submitted on or with the initial claim and/or the appeal request. This may include information regarding the claim provided to the MAC for the first time. The MAC then either modifies or affirms its original decision and effectuates any changes.

It is important to understand that appeals are not all related to whether or not a particular service was or was not medically necessary (i.e. clinical reviews). In fact a significant number of submissions for appeals are non-clinical in nature (i.e. approximately 40%). In addition, there are a number of other factors that complicate the provider's decision to request an appeal as opposed to taking some other type of action. For example, rather than requesting an appeal, a provider might simply have made a clerical error and in fact needs to request a clerical error claim reopening. In this case, the provider would indicate what was missed or keyed wrong for example, and request that the MAC correct the claim and reprocess. Unfortunately, providers do not always understand when this can be done, nor do they make a clear distinction as to what they are asking the MAC to do (i.e. appeal or reopening).

leaving it up to the MAC to review each request and determine the most appropriate course of action to take that will address the provider's request.

Another common problem is that some providers deal with multiple MACs. This can lead to confusion as to which MAC should be sent the appeal for the claim at hand. MACs also must upon appeal receipt, sort out those appeals that belong to other MACs and reroute them for the providers.

There are also issues that surface in appeal requests that are not "appealable issues." These types of requests are handled as inquiries and responded to with letters of explanation rather than as an appeal. These include things such as claims that never processed initially but may have been rejected for not having contained all the needed information.

Finally, there are a number of claims actions that can occur resulting in an overpayment recovery wherein the claim was initially paid then determined to have been paid in error [e.g. probe reviews, Zone Program Integrity Contractor (ZPIC) investigations and Office of Inspector General special study results]. A letter is sent to the provider indicating the need to repay the Medicare Program; this action is eligible to be appealed. When MACs receive these types of appeals, there is an accompanying action that must be taken to cease overpayment recovery efforts within six days of receiving notification of a valid request for appeal.

These sorting type issues are generally limited to the MAC level of appeal as subsequent levels of appeal require that the first level of appeal have been completed. As a result of all these activities performed by the MAC, over the past three years we have received approximately 4 million appeal requests across our three MAC contracts. Of these, approximately 60% were completed and closed as valid appeals while the remaining 40% fell into one of several sorting categories.

The remaining levels of appeal are performed by entities separate and distinct from the MAC. The second level of appeal, termed a reconsideration, is performed by a Qualified Independent Contractor (QIC) with whom CMS contracts specifically to perform this level of appeal. Their work is limited to those claims for which a MAC redetermination has been completed and the provider remains in disagreement with the outcome. This level of appeal again involves a complete case file review of all the MAC appeal materials as well as any new materials submitted by the appellant. The findings are issued in writing to the appellant and sent back to the MAC to effectuate any changes in claims payment outlined in the appeal decision.

The third level of appeal is that conducted by the Office of Medicare Hearings and Appeals (OMHA) and is termed an Administrative Law Judge (ALJ) Hearing and results in a complete de novo review of the entire appeal case, which can also include appellant testimony, and the issuance of an ALJ decision. The decision issued is again returned to the MAC to effectuate any directed changes in claims payment.

Should the appellant disagree with the ALJ decision, the fourth level of appeal is submitted to the Medicare Appeals Council. The Health and Human Services Departmental Appeals Board (DAB) administers this review. As with the other levels, should the DAB overturn the decision in whole or in part, the MAC effectuates the decision as directed. The final level of review is that of the Judicial Review in the U.S. District Court.

GENESIS OF APPEALS BACKLOG

Over the last several years, the number of entities that are involved in the evaluation of claims both pre-claim payment and post-claim payment has increased dramatically, as has the number of claims being scrutinized. In addition to the MAC, these entities include the ZPIC, the Comprehensive Error Rate Testing Program Contractor (CERT), and the Medicare Recovery Auditors (formerly Recovery Audit Contractors) (RA). Each of these entities approaches the review of claims from a slightly different perspective. The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. CMS calculates the Medicare Fee-for-Service (FFS) improper payment rate through the CERT program. Each year, the CERT contractor evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. Finally the RA's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services pro-

vided to Medicare beneficiaries, and the identification of underpayments to providers so that CMS can implement actions that will prevent future improper payments.

The most significant contributor to changes in the volume of appeals has been the RA. As demonstrated in Exhibit II—First Coast Medicare Part A Appeals Volumes, and using First Coast Part A claims as the example, the overall percent of appeals driven by RA decisions jumped from 7% in 2011 to 63% in 2013. Similarly, the overall volume of appeals went from approximately 23 thousand to over 66 thousand for the same time periods. Further, this dramatic increase in appeals was also compounded by the type of claims being reviewed. Predominately the increase involved inpatient claims which are more time consuming to review than the majority of prior appeals received by a MAC, and also require a higher level clinical skill set. Therefore, the resources available to handle these appeals at all levels were impacted by both volume and an increase in needed time to conduct a single appeal. Finally, the high dollar value of these inpatient claims being appealed made it more financially important and more likely that providers would pursue all appeal levels available.

CURRENT EFFORTS TO ALLEVIATE BACKLOGS

To date, a number of actions have been taken to relieve the backlog that now lies primarily at the 3rd (ALJ) level which includes:

- Clarification and Standardization of Documentation Inpatient Admission Rules: CMS published the “Two Midnight Rule” in August of 2013. This rule clarified CMS’s longstanding policy on how Medicare contractors review inpatient hospital claims for payment purposes. In addition to working with MACs to ensure consistent understanding of the rules, CMS also facilitated provider education in the form of probe and educate claim reviews.
- Limited RA inpatient claims review: Along with the rule above, the Protection Access to Medicare Act of 2014 signed into law on April 1, 2014, prohibited RAs from conducting any inpatient hospital status reviews on claims with dates of admission from October 1, 2013 to March 31, 2015 to give the probe and educate process time to be completed.
- Limited RA documentation requests: CMS reduced the minimum medical record requests required of RAs to reduce the administrative burdens on hospitals and other providers, as well as limited the percentage of selected claims to 75% for any one claim type. In addition, CMS carefully reviews each new claim review initiative developed by RAs.
- Hospital Appeals Settlement Project: CMS initiated a project in January of 2015 to allow all eligible hospitals to enter into an administrative agreement in exchange for withdrawing their pending inpatient status appeals. This agreement results in a timely partial payment of 68% of the net allowed amount.
- OMHA Settlement Conference Facilitation Pilot: This pilot is currently limited to Part B appeals for which an ALJ hearing was filed in calendar year 2013 and those not yet assigned to an ALJ. Following CMS and the Appellant reaching agreement, the MAC calculates the settlement amount and issues payment according to the terms of the settlement. As with the process outlined above, the provider relinquishes any right to further appeals on the claims involved.

RECOMMENDATIONS TO STREAMLINE THE APPEALS PROCESS AND REDUCE BACKLOGS

The following is an overview of several recommendations that may effectively reduce the backlog of appeals at the ALJ level and or keep a backlog from reoccurring as well as a recommendation to improve the appeals process while gaining efficiencies.

- Remand cases to the prior level of appeal when the ALJ finds good cause for the submission of new evidence: In cases where new evidence is submitted at the ALJ level, remanding these cases back to the prior level for handling would result in a reduction in the ALJ backlog, as well as quicker resolution for the provider. Further, handling these cases at an earlier level of appeal not only preserves the ALJ level of appeal for the provider when needed, but reduces the expense of having the MAC and the QIC appeals staff prepare for and participate in cases that may indeed be able to be resolved based on the new evidence. Additionally, for reconsiderations that are favorable, there is significant cost avoided by the ALJ as well as the provider and likely the provider would receive payment sooner.

- Establish a per-claim filing fee for appeals brought by providers and suppliers which would be refunded on fully favorable decisions: This would discourage the filing of non-meritorious appeals thereby reducing the backlog and provide a level of funding for reinvestment in program hiring and administration.
- The 1st level of appeal by the MAC could easily be modified to focus on the needed triaging of cases and the processing of cases which do not have a medical necessity component. This would modify the MAC's role from that of performing all of the 1st level appeals to that of triaging appeal requests. This triage would support the continued need to sort out the cases properly addressed as reopenings and/or inquiries, allow rerouting of misdirected appeals to the correct contractor, and timely identification of those valid appeals requiring a hold on the overpayment collection process. Additionally, by limiting the MAC appeal case work to those non-clinical cases would allow the MAC to focus its dollars on the cases most likely to be reversed at this level. The QIC would then be positioned to handle the appeals involving a more complex level of clinical decision making. Most importantly this would eliminate a back and forth of cases going into the QIC and having to be rerouted to the MAC, and the QIC having to hold its appeal receipt waiting for the MAC to prepare the documents it needs to conduct its reconsideration or 2nd level of appeal. Further and with all contractors linking the appeals process through the Medicare Appeals System (MAS), a system that CMS has already implemented, the MACs can initiate the file on the appeals and electronically initiate a case at the QIC level without having to transfer a file.

The operational savings associated with the elimination of the 1st level of clinical appeal could then be redirected into provider education on the most common claim denial findings. These topics would include claims submission accuracy and common documentation pitfalls.

As evidenced by common review findings Exhibit III—Common CERT Errors, providers frequently miss a key element of required documentation not because the patient didn't need the service being billed but because they did not add the few required elements reviewers are required to ensure are evident in the medical records. This error results in the finding of insufficient documentation. Closely related are the issues of medical necessity where the documentation lacks sufficient information to conclude that the patient needed the service billed. With additional funding, the MAC could deliver a more intensive level of training around these issues to keep these types of claim denials from occurring in the first place. Finally, by eliminating a level of appeal, the provider has fewer contractors to deal with and is able to reach the ALJ, Medicare Appeals Council and Federal District Court sooner should they chose those levels of appeal.

In closing, we appreciate the leadership of this Committee in reviewing ways to improve the appeals process and reduce backlogs. We remain supportive of the program and look forward to being part of the solution to these complex challenges. I thank you for the opportunity to testify before this Committee and I look forward to answering your questions.

Exhibit I



Exhibit II

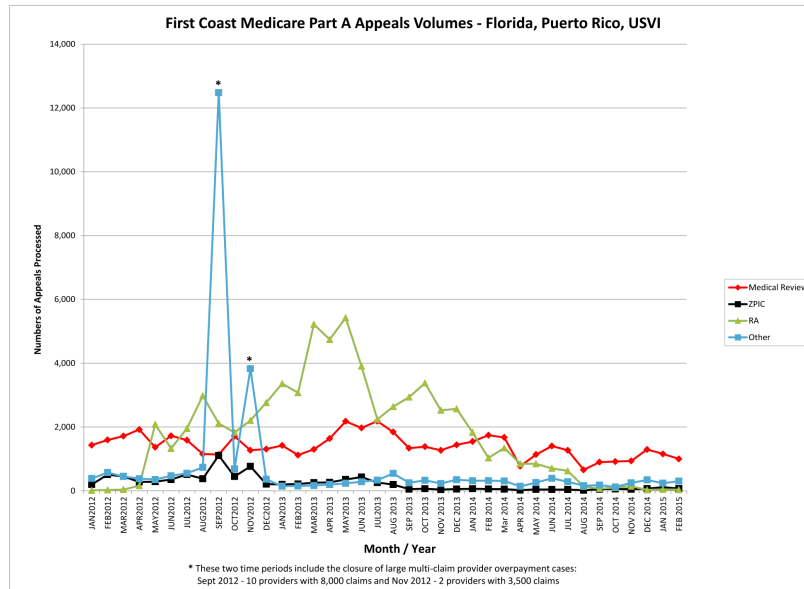
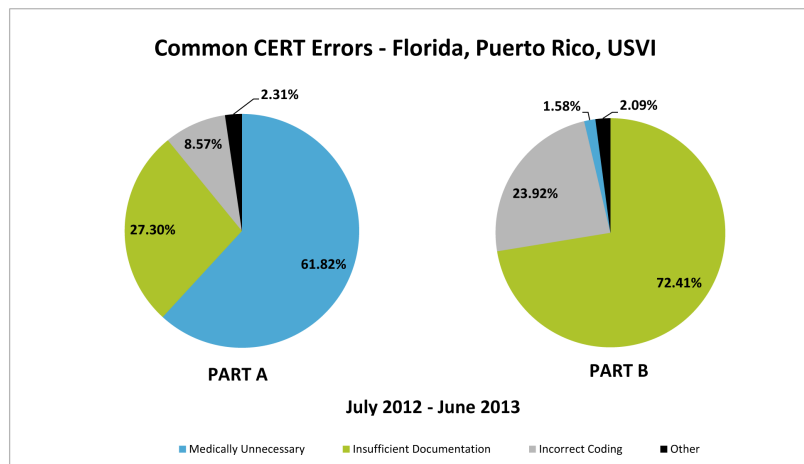


Exhibit III



QUESTIONS SUBMITTED FOR THE RECORD TO SANDY COSTON

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. Providers report that the use of different appeals numbers at various levels of appeal is confusing and hampers efficient tracking. Might you consider implementing a uniform docketing system across various levels of appeal?

Answer. Currently, there is not a single system that facilitates the use of a standardized case numbering protocol across all levels of appeal. The Medicare Appeals System (MAS) is currently used by all Qualified Independent Contractors (QIC) performing second level reconsideration appeals and CMS is in the process of transitioning all Medicare Administrative Contractors (MACs) to the same system (Part A currently transitioning with Part B planned in the near future). The MAS system allows for an indication of cases promoted to the Administrative Law Judge (ALJ) third level of appeal under the QIC MAS number so the two could be linked. The same will eventually be true for the MACs once all MACs have been transitioned to MAS. While the MAC, QIC and ALJ use different numbering systems, the MAS allows for a linkage of these three numbers. Technically, this linking of at least the first three levels of appeal may provide the elements needed to construct a view into the case at the first three levels.

Question. Ms. Coston, are there areas where additional authority would help you address appeals issues prior to going before an ALJ? Are there ways to work through disputes (perhaps even over technical issues) and avoid the appeals system altogether?

Answer. Additional authority that would help us address appeals issues includes requiring all documentation be submitted with the first level of appeal prior to being able to appeal to the next level.

If this authority cannot be granted, then as we discussed, giving the QICs and the ALJs the authority to remand an appeal back to the prior level would be helpful to getting the documentation needed from the onset for all cases. Additionally, the first level of appeal could include an outreach (development for additional information) to the provider when it is clear that documentation is missing (example, a diagnostic test missing a physician order) although this would have a cost impact to the MAC's processes.

With regard to working through disputes to avoid the appeal system altogether, there are ways to assist the provider in getting their claims paid through individual outreach and education. It is not unusual for MAC staff to walk a provider through a processing issue that involves a number of claims. However, the key to success is for the provider to sustain the education as this individual outreach and education can be very costly.

Question. What thoughts do you have on the President's budget proposals and whether they will make the differences purported, or do we need to continue to also explore other legislative alternatives?

Answer. As this primarily affects ALJ resources, Chief Administrative Law Judge Griswold is in a better position to comment.

Question. Finally, as we continue to develop our statutory response to these issues, what would be the one thing that you would change to improve the flow of the appeals process?

Answer. As noted in our response to Question 2 above, we would recommend requiring all documentation be submitted with the first level of appeal prior to being able to appeal to the next level.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. For the last couple of years, there has been constant controversy over the battle between Medicare providers, especially hospitals, and recovery audit contractors (RACs). When an appeal is heard, someone wins and someone loses, but there's no public scorekeeping of wins and losses. We believe that open accounting could cut down on frivolous findings by RACs, frivolous appeals by providers, and lackadaisical rulings from the reviewers.

There is a value in transparency when government is engaged in the people's business. In this case, the appeals process is in desperate need of transparency. Reg-

ularly, I will have providers tell me they win 90% of their appeals. Then minutes later, I will get visits from auditors who tell me they are winning 90% of their appeals. Clearly, those numbers do not add up.

The appeals process would benefit from an open and transparent accounting of appeals outcomes. If we are concerned about frivolous findings against providers, frivolous appeals of auditor findings, and reviewers not devoting adequate consideration to the policy issues, transparency would shine a light on all parties to the process.

Is there any reason you can think of that we should NOT publish, in the aggregate, the appeals outcomes, essentially wins and losses by provider and auditor at your level of the appeal process?

Answer. We are a proponent of transparency and distribution of information. However, it should be recognized that numbers and win/loss ratios can be deceiving. The system is much more complicated than can be represented by aggregate numbers on a portion of claims that have been appealed. For example, a provider may claim to have a 90% win rate but then again, they may have only appealed a small percentage of claims which were denied. Most providers are very selective about what they choose to take to the next level of appeal. Similarly, an auditor may claim a 90% win rate for the universe of cases that actually get appealed to the next level, but this does not mean that the provider referenced above appealed all their cases to the next level. To be accurate, one would have to take the universe of the denied claims, as the denominator and the universe of the "won" claims on appeal to arrive at the correct ratio.

Further, there is an enormous variation in the different kinds of audits and auditors (e.g., MACs, QICs, Recovery Auditor Contractor (RAC), etc.) as to why they are reviewing a particular service. For example, a MAC might be reviewing a claim that was selected based on the aberrant billing pattern of the individual provider, while the RAC may be looking at a particular service across a larger universe of providers and is focused on verifying medical necessity. While we would agree therefore that publication is good, it would require careful consideration of the appropriate data elements and what the data means before publication.

Question. Is there any reason you can think of that we should NOT publish, in the aggregate, the appeals outcomes by the specific ALJs so we can look at them comparatively?

Answer. One would have to be very clear about the case mix each ALJ reviewed and the reasons for the original denial that drove the appeal. If one could outline all factors that cause appeal outcome variances, then publishing would be appropriate. This would however be very complex.

One also would have to consider that all upheld unfavorable decisions at one level are not necessarily appealed to the next level. The best representation of activity would be to look at one type of audit (e.g., RAC inpatient status reviews) noting the initial volume of claims selected for audit, the initial denial rate, then noting the rate of reversal for those same claims as they move through the levels of appeal.

QUESTION SUBMITTED BY HON. JOHN THUNE

Question. Ms. Coston, in your written testimony, you stated that approximately 40 percent of appeals are non-clinical in nature, and that providers often appeal to a Medicare Administrative Contractor (MAC) without making clear what action the provider would like to take. Why is it that after a decision is made by a Recovery Auditor (RA) that providers are still not sure whether they made a clerical error? Do RAs need to do more to educate providers about its determination?

Answer. The 40 percent of appeal that are non-clinical in nature are not necessarily those driven by the RA. Most are related to claims submission issues where the decision to deny was a result of the MACs prepayment safeguards. That said, the MACs could develop and carry out additional educational efforts to assist providers in complex claim submission.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

Question. What opportunities exist to improve the consistency and predictability of the audit and appeals processes from both a provider and an auditor's perspective while striking the right balance to ensure Medicare program integrity?

Answer. From a provider's perspective, there needs to be clear guidelines of coverage and examples associated with those guidelines as to what adequate documentation looks like. From the auditor's perspective, there needs to be provider documentation that is adequate to allow a determination to be made as to whether or not the patient meets the coverage guidelines.

The educational focus needs to be on giving providers information about what services Medicare covers and under what circumstances those services are considered to be payable. This would include augmenting existing education and developing educational vehicles that engage the provider who is documenting the record vs. the provider's ancillary staff. Again, additional education should be focused on coverage criteria vs. claim coding and submission.

Question. In 2013, Medicare's improper payment rate was above 10 percent. In your testimony you note that the most significant contributor to changes in the volume of appeals has been the Recovery Auditors, and the overall percent of appeals driven by Recovery Auditor decisions increased from 7 percent to 63 percent in 2013. What are some of the quality checks currently in place to ensure that Recovery Auditors do not place undue burden on providers, and that their audits are efficient and error free?

Answer. With respect to the current quality check in place to ensure that the Recovery Auditors do not place undue burden on providers, the Recovery Audit contractors and CMS would be best positioned to explain the safeguards in place.

However, CMS has implemented several actions to limit the burden on any one provider in terms of the number of audits that are done at any given time. Additionally, CMS reviews each audit subject prior to its initiation.

Question. What efficiencies and cost-savings could be gained by no longer having MACs as the first level of appeal?

Answer. We recommended that the first level of appeal involving medical necessity clinical review be moved to the QIC. The result would eliminate the cost of clinical review activities at the first level of appeal and provide the appellant with quicker access to a decision maker with provider-like credentials, i.e., a physician, prior to any decision to uphold the denial.

Question. Would provider education and outreach help to address the concern that providers may not always understand the distinction between appealing versus reprocessing a claim?

Answer. Definitely. This education could be targeted to include the provider's ancillary staff as they can easily identify data entry errors, claim coding issues and submission errors where the addition or correction of information can be conducted via the reopening process and does not need to go through the appeal process.

 QUESTIONS SUBMITTED BY HON. RON WYDEN

APPEALS PROCESSED AND RESOLVED AT EACH LEVEL

Question. Providers, suppliers, and beneficiaries have the ability to appeal audit decisions through an administrative appeals process. The levels of administrative review and adjudication include the redetermination—as performed by the Medicare Administrative Contractor, the reconsideration—as performed by the Qualified Independent Contractor, the hearing conducted by an Administrative Law Judge in the Office of Medicare Hearings and Appeals (OMHA), and the review conducted by the Medicare Appeals Council, Department Appeals Board. In recent years, there has been a notable influx in the number of appeals requested. As a result, certain levels of the appeal process have become substantially backlogged.

How many claims are appealed to your level of review annually? How does this number differ from historical annual appeal requests?

Answer. Following is data for First Coast for Jurisdiction 9 (now Jurisdiction N):

Part A

Year	2010	2011	2012	2013	2014
Part A Appeals Volume	18,576	22,714	42,641	63,463	24,614
RAC A within the above	738	1,615	16,851	41,436	7,329

Part B

Year	2010	2011	2012	2013	2014
Part B Appeals Volume	295,081	276,784	316,398	317,124	335,217
RAC B within the above	0	841	4,022	2,205	2,202

Following is data for Novitas for Jurisdiction H (note that 2012 is a partial year):

Part A

Year	2010	2011	2012	2013	2014
Part A Appeals Volume	NA	NA	11,597	89,664	72,341
RAC A within the above	NA	NA	4,458	46,787	43,000

Part B

Year	2010	2011	2012	2013	2014
Part B Appeals Volume	NA	NA	18,351	287,664	225,064
RAC B within the above	NA	NA	2,377	10,559	2,836

Following is data for Novitas for Jurisdiction L:

Part A

Year	2010	2011	2012	2013	2014
Part A Appeals Volume	19,409	30,656	50,615	64,190	46,079
RAC A within the above	110	5,928	20,098	25,191	15,196

Part B

Year	2010	2011	2012	2013	2014
Part B Appeals Volume	182,433	181,788	198,360	200,214	227,576
RAC B within the above	101	4,669	3,669	1,135	4,106

Question. Of the total number of claims appealed to your level, how many receive an unfavorable decision? If possible, provide this information in aggregate and broken down by appeal claim type (e.g., Part A).

Answer. Following is data for First Coast for Jurisdiction N:

Part A

All Processed	05/2014–04/2015		
	Total	Unfavorable	Percent
Part A	18,619	8,136	43.70%
RAC	RAC is also included in the All Processed, above		
Part A RAC	2,574	1,225	47.59%

Part B

All Processed	05/2014–04/2015		
	Total	Unfavorable	Percent
Part B	332,897	158,393	47.58%
RAC	RAC is also included in the All Processed, above		
Part B RAC	1,538	1,014	65.93%

Following is data for Novitas for Jurisdiction H:

Part A

All Processed	2014		
	Total	Unfavorable	Percent
Part A	71,386	52,596	74%
RAC	RAC is also included in the All Processed, above		
Part A RAC	42,887	39,090	91%

Part B

All Processed	2014		
	Total	Unfavorable	Percent
Part B	197,857	107,174	54%
RAC	RAC is also included in the All Processed, above		
Part B RAC	2,017	564	28%

Following is data for Novitas for Jurisdiction L:

Part A

All Processed	2014		
	Total	Unfavorable	Percent
Part A	45,768	24,844	54%
RAC	RAC is also included in the All Processed, above		
Part A RAC	14,350	11,058	77%

Part B

All Processed	2014		
	Total	Unfavorable	Percent
Part B	173,100	89,913	52%
RAC	RAC is also included in the All Processed, above		
Part B RAC	2,982	881	30%

Question. Of the total number of appeals that receive an unfavorable decision at your level, how many of those are subject to additional review at the request of the appellant (i.e., are appealed to the next level)? If you note any trends in cases that proceed for additional review, please break out the data accordingly.

Answer. First Coast is only able to state the number of appeals that went to the next level of appeal (2nd Level QIC) based on their request for our case file:

Part A

QIC Request Received	2012	2013	2014
Total	12,912	44,680	10,873

Part B

QIC Request Received	2012	2013	2014
Total	31,148	45,894	44,727

Novitas is only able to state the number of appeals that went to the next level of appeal (2nd Level QIC) based on their request for our case file for Jurisdiction H (note that 2012 is a partial year):

Part A

QIC Request Received	2012	2013	2014
Total	5,029	42,221	52,521

Part B

QIC Request Received	2012	2013	2014
Total	4,220	31,291	25,743

Novitas is only able to state the number of appeals that went to the next level of appeal (2nd Level QIC) based on their request for our case file for Jurisdiction L:

Part A

QIC Request Received	2012	2013	2014
Total	18,679	32,408	19,406

Part B

QIC Request Received	2012	2013	2014
Total	17,132	17,245	17,381

THE USE OF MEDICAL EXPERTISE TO ADJUDICATE MEDICALLY COMPLEX CASES

Question. Anecdotally, I have been informed that cases involving “medical necessity,” or those cases which require significant clinical review and input to effectuate, are most frequently subject to higher level appeal requests. I also understand that such cases are timely to review, and at the lower levels of appeal are reviewed by a clinician, such as a nurse and/or physician.

Can you discuss how such cases are currently processed at your level of review?

Answer. At the first level of review, cases are sorted upon initial receipt. Once those that can be handled as reopenings are identified, those that remain are sorted based on the basis of the initial claim denial. Any case that involved a clinical review prior to payment goes to a clinician to review at the appeal level. The rest are primarily technical in nature (e.g., modifiers, number billed, procedure and diagnosis coding) and generally involve cases that will be handled as inquiries or dismissed as not being valid appeals.

MACs have nurses who review the cases and apply guidelines approved by the Office of the Contractor Medical Director. These cases are not, however, given a level of physician review unless the nurse is dealing with a very unusual case (mostly associated with new technology) where we have an established process for referring cases for a higher level of review.

Question. Do you think there would be a benefit in requiring medical expertise to be uniformly incorporated at all levels of the administrative appeals process? Why or why not?

Answer. Based upon our recommendation for the MAC to forward medical necessity cases to the QIC, effectively eliminating the first level of appeal, there would be an inherent uniformity of medical expertise.

However, if the recommendation to eliminate the first level of appeal for medical necessity cases is not adopted, we do not necessarily think there would be a benefit in requiring medical expertise to be uniformly incorporated at all levels. Once a case is at the second level of review which is performed by the QIC, any case that the nurse determines cannot be overturned and paid will be secondarily reviewed by a physician before the denial of the case stands. This second level of review is more costly than the first level of review. Additionally, there tend to be fewer providers who “appeal everything” at the QIC level. These cases tend to be more likely to need clinical review. It would be much more efficient to have the MAC focus on logging cases and sorting those that can be handled as reopenings, leaving the clinical review to be focused at the QIC level.

Currently, MACs and QICs have the option of participating at the ALJ level of appeal. We believe this participation provides medical expertise to be uniformly incorporated through the third level of appeal.

Question. Do you have any other suggestions to improve the Medicare appeals process for cases involving medical necessity?

Answer. Establish consequences for not submitting all the documentation the first time the case is appealed. The case history often reflects that the appellant did not provide the needed documentation (outlined in published policy) until the QIC or ALJ levels of review. Availability of this documentation increases the likelihood that a complete medical necessity review will be conducted at the first level of appeal.

IMPROVING EFFICIENCY THROUGH ELECTRONIC CASE FILES AND “INTEROPERABILITY”

Question. During the hearing, each witness reiterated that the adoption of electronic case files across all levels of review could significantly improve the efficiency of the Medicare appeals process. Additionally, Mr. Naughton discussed the potential benefits of having interconnectivity between the existing and future electronic systems, so that: (i) appellants could more easily ascertain their current status in the administrative appeals process, and (ii) reviewing entities were assured that the case file was transmitted in its entirety.

Can you share how documents are electronically processed at your level, including the interconnectivity of such systems?

Answer. When cases are received (whether by secure Internet portal, traditional mail or fax), it generates an imaged document which is housed in our image repository. Most MACs have developed some type of home grown system to facilitate the processing of these appeal cases. When the appellant request the 2nd level of appeal of the QIC, the QIC sends a faxed case file request. The fax is scanned and also becomes an imaged document. Once this request is received, a case file is created that links our original case file (the documents and decisions associated with the 1st level appeal) with the request and returns the package electronically to the QIC via a secured connection. The only connectivity we have with the QIC is this connection to send case files to them. See also response to the question below.

Question. How could electronic case files be more thoroughly integrated across all levels of review?

Answer. If all parties were using the MAS (currently in place at all QICs with CMS rolling out use to all MACs for Part A case work with plans to eventually include Part B), the MAC could create the initial case file once it determines the submission to be a valid appeal. All of the documents would then be uploaded into MAS for immediate access by the QIC. Additionally, if the ALJs were also linked into this system or had a method of moving their case file requests and decisions to MAS, the first 3 levels of appeal (the overwhelming majority of cases) could be accessed by all. This would also tremendously increase the level of analysis that could be done on case trends, reversal trends and the reasons for those reversals to feed the quality improvement processes at each contractor.

Question. Please expand on the expected benefits to the appeals process should such suggestions be adopted.

Answer. As stated above, virtually all of the time spent requesting, preparing and sending case files across contractors would be eliminated. There would be transparency of decision making across the contractors to facilitate quality initiatives around better and more consistent decision making. Ultimately, the time to conduct the appeal would be reduced for the provider and beneficiary by eliminating the portion of time spent routing case files and decisions back and forth.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

REDETERMINATION AND RECONSIDERATION

Question. One of the ways the Department of Health and Human Services (HHS) helps to protect the Medicare Trust Fund is by conducting audits to ensure the appropriateness of the services provided. Providers and beneficiaries have the ability to appeal audit decisions through an administrative appeals process.

Medicare Administrative Contractors (MACs) are charged with auditing claims for appropriateness, processing claims through the system to provide payment, and educating providers about Medicare rules. MACs generally conduct their reviews prior to payment, and are paid through traditional contracts. Redetermination reviews, performed by the MACs, are the first level of review under the Medicare audit and appeals process. They are conducted by clinicians for medical necessity purposes and non-clinicians for other types of appeals.

Ms. Coston—what is the annual budget (or how much does HHS spend) per year on processing redeterminations?

Answer. We do not have the HHS numbers. However, our annual appeals budget is approximately \$28.5 million to process reopenings, redeterminations and other appeals related work.

Question. Reconsideration reviews are the second level of review, performed by Qualified Independent Contractor (QICs)—generally a nurse or a physician—operating under the oversight of CMS.

Ms. Coston—do you believe that current policies and procedures at the MAC and QIC levels provide sufficient support to beneficiaries, who are often left to pursue these claims on their own?

Answer. Often times beneficiaries are confused by the appeals process due to the complexity of the Medicare program. The 1-800 Medicare line is their source of re-

ceiving direct assistance. MAC contractors are separate and apart from the 1-800 Medicare contractor.

We do believe that our current policies and procedures as a MAC are sufficient to support beneficiaries. The MACs are charged with obtaining from the beneficiaries' provider any needed medical record documentation that may be missing in order to conduct a beneficiary submitted appeal. We are unable to comment on the QIC's policies and procedures.

Question. What more can be done to ensure beneficiaries are aware of their rights and understand the appeals process and the information necessary to make a successful claim? What more can be done to make sure that the Redetermination and Reconsideration levels of appeal are more meaningful for beneficiaries?

Answer. The 1-800 Medicare contractor has the direct relationship with the beneficiaries for outreach and education. This work has never been part of the MAC contracts. We are completely familiar with all of the efforts of the 1-800 Medicare contractor, so this question would be better answered by them. Additionally, most beneficiaries are dependent upon their physician to tell them what Medicare will and will not cover.

Question. Ms. Coston's written testimony suggests that the MACs' role should be modified to "triaging" cases and appeals and limiting its processing to non-clinical cases.

Ms. Coston—would it be possible to go further and have one contractor handle both the triaging function and the processing of cases under one roof, effectively merging those functions into one entity and dispensing with one of the two lower levels of review? If yes, do you have suggestions for how that could work? If no, why not?

Answer. Currently the MACs are responsible for triaging and the processing of the first level of appeal. As we recommended, we do believe the first level of appeal can be eliminated for medical necessity cases by routing these cases directly to the QIC.

RECOVERY AUDIT CONTRACTORS (RACS)

Question. RACs are another tool CMS uses to audit potentially improper payments. The RAC system was permanently established by Congress in 2010, following a 3-year demonstration. RACs are paid on a contingency-fee basis based on their identification of improper payments.

In 2012, RACs returned almost \$2 billion to Medicare. Over half of the funds appeals received by the Office of Medicare Hearings and Appeals (OMHA) are RAC-related. Today, OMHA is funded only by discretionary appropriations.

It seems as though the enormous spike in appeals that has overwhelmed the system is mainly attributable to hospital appeals of RAC determinations.

Ms. Coston—would you support a separate appeals system for those claims? Do you have suggestions for how that could work?

Answer. We would not suggest a separate appeals system for RA claim audits. The RAs are still looking at claims that were processed by the MACs. Each MAC knows how and why, the rules followed and such particular to that claim that can be very different from MAC to MAC depending again on the system editing and local coverage policy in effect for that jurisdiction.

MAKING THE SYSTEM MORE FRIENDLY FOR BENEFICIARIES

Question. Despite the fact that the Medicare appeals system was created with beneficiaries in mind, we know that it is providers who file the vast majority of appeals. In 2010, for example, Medicare beneficiaries filed just 11% of the appeals heard by ALJs.

Today, beneficiary-initiated appeals continue to make up a proportionally small percentage of the total number of appeals, but they continue to get lost in the shuffle.

Ms. Coston—what can be done to help beneficiaries who filed *before* the prioritization process was put into effect, and have been waiting the longest? How are their inquiries handled if they call 1-800-Medicare?

Answer. This question is best answered by either the ALJs or the 1-800-Medicare contractor. Once the appeal is promoted to the QIC or ALJ level, the MAC has no jurisdiction to engage in the processing of that appeal. Certainly all beneficiary appeals could be handled by a special council which could include MAC staff to handle them but this would certainly be outside of the rules currently.

The 1-800-Medicare calls are handled by a contractor other than the MACs.

QUESTION SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Thank you for your testimony highlighting the serious issue of the Medicare appeals backlog. In your testimony, you stated that the most significant contributor to changes in the volume of appeals has been the Medicare Recovery Auditors (RAs, formerly known as Recovery Audit Contractors or RACs), noting that, using First Coast Part A claims as an example, “the overall percent of appeals driven by RA decisions jumped from 7% in 2011 to 63% in 2013.”

I would like to bring to your attention an article recently published in the *Journal of Hospital Medicine* regarding RAC audits and appeals of complex Medicare Part A cases at three academic medical centers (University of Wisconsin Hospital, University of Utah Health Care and Johns Hopkins University Hospital).¹ Sheehy *et al.* found that:

- RAC overpayment determinations increased nearly three-fold during the last two calendar years of the study (from 680 in 2010–2011 to 1,856 in 2012–2013), while the hospitals won, either in discussion or appeal, a combined greater percentage of contested overpayments each year (from 36.0% in 2010, to 38.5% in 2011, to 46.1% in 2012, to 68.0% in 2013).
- One-third (33.3%, 645/1935) of all resolved cases were decided in favor of the hospital during the discussion period, with these discussion cases accounting for two-thirds (66.8%) of all favorable resolved cases for the hospital.

As noted above, the majority of successfully contested cases occurred in the discussion period. However, because the discussion period is not considered part of the formal appeals process, those cases are not included in CMS or OIG reports of RA activity, suggesting that RA auditing accuracy may have overestimated in those reports. Additionally, the percentage and total number of determinations successfully disputed by hospitals increased in each year studied, reaching two-thirds of all cases in 2013, which raises questions about the RAs’ internal quality control processes.

Given your role in processing Medicare appeals, would you support a proposal to mandate future federal reports of RA auditing and appeals to include cases overturned in the discussion period; carefully describe the denominator of total audits and appeals given the likelihood that many appeals in a given year will not have a decision in that year; and report Complex Part A, complex Part B, semiautomated, and automated reviews separately?

Answer. We support publishing the results of audits; however, the most accurate way to track the accuracy of any audit process is to segregate numbers based on the type of claim reviewed within a single audit. For example, the RAC initiated inpatient claim reviews and selected claims in distinct data runs. Each claim selected within a data run should become a discrete denominator and tracked across the appeals process until the appeals process is exhausted. To mix samples and denominators would not display an accurate representation. At the end of each data run, that summary data could be aggregated for reporting on the results of the audits for the inpatient claims only as used in this example.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. As the panel has pointed out, the Office of Hearings and Appeals (OMHA) received more than 654,000 claims in FY2013, up from under 60,000 in FY2011, which has increased the backlog and average processing time for an appeal’s decision. What do you believe are the primary causes of this dramatic increase in claims? And to follow-up, what are some commonsense, balanced fixes to

¹Sheehy AM, Locke C, Engel JZ, Weissburg DJ, Mackowiak S, Caponi B, Gangireddy S, Deutschendorf A, Recovery audit contractor audits and appeals at three academic medical centers, *J Hosp Med.* 2015 Apr;10(4):212–9.

address the backlog that could help ensure that seniors and their physicians are able to receive and provide needed care?

Answer. The backlog, as stated in my written testimony, was directly attributed to the implementation of the RAC contractors. With the method of their payment being dependent on their recoveries, it makes sense that the RAC reviewed the highest dollar claims where it was likely that the documentation would be insufficient. It also is logical that the hospitals, with so much money at risk, have continued to pursue relief through the appeals process. CMS has effectively implemented a solution with the Hospital Appeals Settlement Program which has allowed providers to elect to settle cases in lieu of continuing through the appeals process.

Question. It's my understanding that while the vast majority of providers are acting in good faith and filing appropriate and necessary appeals, there may be a few bad actors taking advantage of this broken system. As highlighted in a recent HHS Office of the Inspector General (OIG) report, two percent of providers represent one-third of all appeals. It is important that the Medicare audits and appeals system has the capability to protect taxpayer dollars from exploitation by the few who are bogging down the system for their own financial gain. In your view, what can be done to alleviate the system from the burden of these bad actors?

Answer. We recommend a two-prong approach. The first is to levy a fee on providers who submit appeals. If they are found to be fully favorable, the fee would be refunded. This would discourage the filing of non-meritorious appeals thereby reducing the backlog and provide a level of funding for reinvestment in program hiring and administration. This should follow some level of documented provider education by the contractor and a pattern of continuing to submit appeals when the provider has received prior denials upheld. The second is to make this behavior criterion in determining whether or not a provider should be sanctioned. Repeated behavior that demonstrates a refusal to submit claims correctly should have consequences, such as removal from participation in the Medicare program.

Question. Historically, CMS has relied on claims administration contractors to protect taxpayer dollars in the Medicare Trust Fund. Since 2005, Medicare has used Recovery Audit Contractors (RACs) to recover improper payments to providers. Although RACs have had some success in returning improper payments to Medicare, their incentives to recover payments for Medicare have come under significant scrutiny. RACs are paid a percentage of every overpayment they identify and collect from providers, and while some adjustments have been made to their payment structure, their contingency-based payment contracts still incentivize RACs to recover as many payments as possible. Some have argued that aggressive RAC payment recoupment behavior has contributed to the increase in appeals, as providers appeal more and more claims. What role do you think RACs play in contributing to the backlog of claims that is preventing seniors from getting needed care?

Answer. The backlog, as stated in my written testimony, was directly attributed to the implementation of the RAC contractors. We are not aware that this backlog has prevented seniors from getting needed care.

Question. Ms. Coston, as you are well aware, many rejected claims and appeals result from differences in regional coverage of services or therapies. I have heard from many Colorado seniors who find out that a service or therapy they need is covered in another Medicare region but not in theirs. Often, it can take months or even years to get that same service or therapy covered, leaving patients to suffer as they wait for approval. Can you please provide some thoughts on the Local Coverage Determination process, and whether it benefits seniors in the most efficient way to ensure they have access to needed services and therapies?

Answer. MACs develop local coverage determinations (LCD) through a very specific process that involves input from the Medicare provider community. Representatives from professional physician groups across the jurisdiction participate in providing discussion and comment on policy based on standard medical practice in that jurisdiction. LCD topics are selected based on requests from providers for coverage and/or to support the implementation of prepayment claims review activities around services that are being used improperly in the jurisdiction. It is not unusual for one part of the country with an academic center of excellence to develop new technology and have it become more main stream in practice ahead of other parts of the country. Similarly, some jurisdictions have pockets of improper use and abuse of services that necessitates establishing a LCD to support audit activities.

Question. Ms. Coston, I believe you mentioned that there is an opportunity to better educate providers on appropriate documentation and the proper claims submission

sions process. You also mention in your testimony that some requests from providers might be better addressed outside of the appeals process. Without adding additional administrative burden, can you please elaborate on the best ways to educate providers on the appeals process?

Answer. We routinely test ways to aid the provider community in submitting claims correctly, correcting claim errors quickly and helping them to appeal with adequate documentation to minimize rework on everyone's part. While certainly funding is always a factor, one of the ways in which we are trying to change this situation is through the development of self service solutions such as our secure Internet portals. The portals are designed to guide providers through the use of templates to follow the process to submit the correct information.

PREPARED STATEMENT OF HON. NANCY J. GRISWOLD, CHIEF ADMINISTRATIVE LAW JUDGE, OFFICE OF MEDICARE HEARINGS AND APPEALS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and Members of the Committee, thank you for the opportunity to discuss proposals for creating a more efficient process for Medicare appeals. The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge (ALJ) hearing program for Medicare claims and entitlement appeals under sections 1155, 1869, 1876, 1852, and 1860D, of the Social Security Act (the Act). OMHA is charged with providing a fair and impartial forum in which Medicare beneficiaries, and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage Organizations and Medicaid State Agencies, are able to resolve disagreements with Medicare claim determinations.

BACKGROUND

Three separate agencies within HHS are charged with administering the four levels of administrative review of Medicare claims appeals within HHS. There is a fifth level of review with the federal district courts after administrative remedies within HHS have been exhausted. The first two levels of review are administered by the Centers for Medicare and Medicaid Services (CMS) and conducted by Medicare contractors. The third level of review is administered by OMHA and is conducted by ALJs. Subsequent reviews are conducted at the fourth level of appeal within the Medicare Appeals Council, which is within the Departmental Appeals Board (DAB), and at the fifth level by the federal district courts. In addition to Medicare claims appeals, individuals may appeal a determination by the Social Security Administration (SSA) that they are not entitled to Medicare benefits. This Medicare entitlement appeals process consists of three levels of administrative review and a fourth level of review with the federal district courts after administrative remedies have been exhausted.

HHS established OMHA in June 2005, pursuant to section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) (MMA), which required the transfer of responsibility for the ALJ hearing function of the Medicare claims and entitlement appeals process from the SSA to HHS. OMHA was established to improve service to appellants and to reduce the then average 368-day waiting time for a hearing decision that appellants experienced with SSA to the 90-day time frame for issuing dispositions established in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554).

In order to make certain that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency within HHS, reporting directly to the Secretary. Accordingly, OMHA operates under a separate appropriation and is both functionally and fiscally separate from CMS.

At the time OMHA was established, Congress envisioned that OMHA would receive the same mix of work which had been handled by SSA:

- Claim and entitlement appeals workload from the Medicare Part A and Part B programs;
- Coverage appeals from the Medicare Advantage (Part C) program;
- Appeals of Income Related Monthly Adjustment Amount (IRMAA) premium surcharges assessed by SSA, and

- A new workload of appeals from the Medicare Prescription Drug (Part D) program.

With this mix of work at the expected levels, OMHA was initially able to meet the 90-day time frame that Congress contemplated for most appeals coming before the new agency. However, starting in Fiscal Year (FY) 2010, OMHA began to experience an upward trend in the number of requests for hearings being filed, which resulted in longer average processing times for appeals.

Although it is impossible to assign any single cause to the rapid growth in Medicare appeals, it is possible to identify a number of probable contributing factors. In 2010, OMHA began to take on new workloads, including appeals that result from the Recovery Audit program, which Congress established in 2006 and expanded nationwide beginning in 2010. While the program has led to more appeals as providers exercised their right to a hearing, the program has also reduced improper payments and returned significant dollars to the Medicare Trust Funds. During these same years, OMHA also experienced a concurrent growth in its traditional workload. Between FY 2009 and FY 2014 OMHA's traditional workload increased 543%. In FY 2011 and FY 2012, OMHA also noted an increase in the number of appeals filed by Medicaid State Agencies (MSAs) related to treatment for beneficiaries dually enrolled in both Medicare and Medicaid. Finally, Medicare enrollment has grown as the Baby Boom generation becomes Medicare-eligible. Recent increases in SSA disability adjudications have also resulted in the influx of larger numbers of younger disabled individuals becoming eligible for Medicare benefits. This increase in the number of beneficiaries utilizing Medicare services may be resulting in a higher universe of potential disputes.

Although ALJ team productivity (dispositions per ALJ team) has more than doubled from FY 2009 through FY 2014 (from an average of 472 dispositions per ALJ team per year in FY 2009 to 1,049 in FY 2014),¹ the magnitude of the increase in workload has exceeded OMHA's ability to adjudicate incoming appeals within the 90-day time frame that Congress contemplated for most appeals. As a result of the significant disparity between workload and capacity, adjudication time frames have increased to their current level of 572 days (as of February 28, 2015), and will continue to increase until receipt levels and adjudication capacity are brought into balance.

In an effort to mitigate the impact of increased wait times on individual beneficiaries, who we believe to be our most vulnerable appellants, OMHA implemented a prioritization policy to ensure that appeals filed by beneficiaries are assigned to ALJs and heard as quickly as possible. These beneficiary-initiated appeals comprise approximately 1% of all appeal requests OMHA receives, but often concern emergent issues such as requests for pre-service authorization. As a result of this prioritization policy, the average time to decision for beneficiary appeals has improved. In February 2015, we estimated that the average time to decision for beneficiary appeals decreased from 244.6 days in FY 2013 to 125.0 days in FY 2014 (this calculation does not include Part D expedited appeals, which operate on a much shorter (10-day) time frame).

Over the past 5 years, OMHA has worked to maximize its productivity by supporting each of its ALJs with enhanced processing teams consisting of attorneys and other support staff. This has allowed each ALJ to focus on hearing and deciding appeals—functions which can only be performed by ALJs. However, OMHA's adjudication capacity is still limited by the number of funded ALJ teams. Under the 2014 continuing resolution, OMHA's funding level supported 65 ALJ teams. Enacted funding increases in FY 2014 and FY 2015 have allowed for the hiring of 12 additional ALJ teams, bringing OMHA's adjudication capacity to 77,000 appeals. This funding also enabled OMHA to open its fifth field office in Kansas City, the first additional office since OMHA opened its doors in 2005. However, even this additional capacity pales in comparison to the adjudication workload. In FY 2013 alone, OMHA received approximately 384,000 appeals, and in FY 2014, approximately 474,000 appeals were received.

¹ These numbers do not include dismissals or remands. When dismissals are included, the disposition numbers are 551 per ALJ team per year in FY 2009 and 1,505 per ALJ team per year in FY 2014. The dismissal numbers were higher than normal in FY 2014 due to appellants withdrawing Part A appeals to avail themselves of a then-new option for rebilling of hospital services under Part B and a single appellant's withdrawal of a significant number of appeals as the result of a negotiated court settlement. However, these levels do not represent a sustainable disposition capacity for the agency.

In the face of dramatically increasing workloads, the Department recognized the need to deliver high quality and timely decisions on benefits and services to the Medicare community with greater efficiency, and under Secretary Burwell's leadership the Department has undertaken a three-pronged strategy to improve the Medicare Appeals process: (1) Take administrative actions to reduce the number of pending appeals and to appropriately resolve claims at earlier levels of the appeals process; (2) Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; and (3) Propose legislative reforms that provide additional funding and new authorities to address and mitigate the appeals volume. The FY 2016 Budget includes a comprehensive legislative package of seven proposals aimed both at helping HHS process a greater number of appeals and facilitating the appropriate resolution of appeals at earlier levels of the process. The FY 2016 Budget also requests additional resources to enhance OMHA's capacity to process appeals.

ADMINISTRATIVE ACTIONS TO REDUCE THE NUMBER OF PENDING APPEALS AND APPROPRIATELY RESOLVE APPEALS AT EARLIER LEVELS OF THE APPEALS PROCESS

OMHA has taken the following administrative actions:

- ***Leveraging Information Technology to Increase Efficiency***—OMHA's ALJ Appeal Status Information System (AASIS) was released in December of 2014, and increases the accessibility of basic information related to appeal status by implementing a searchable database, which appellants can access through OMHA's website. Electronic Case Adjudication and Processing Environment (ECAPE) is OMHA's most ambitious electronic initiative and will convert our business process from paper to electronic over the next two years. ECAPE is planned as a three phase implementation with the first release tentatively scheduled for early spring of 2016. In anticipation of the movement from paper files to electronic records, OMHA has entered into a scanning contract, which will allow conversion of existing paper appeal files into electronic format. OMHA has also developed a Medicare Appeals Template System (MATS), which simplifies the work of our staff by providing standardized fillable formats for routine word processing.
- ***Judicial Education Training***—In July 2010, OMHA implemented mandatory yearly training for ALJs, and expanded the program to include other members of the adjudication staff in 2012. These sessions provide consistent training to adjudicators on policy issues related to Medicare appeals and routinely involve collaborative training using policy experts from OMHA, CMS, and the DAB. Special sessions have also included participation from the HHS Offices of the Inspector General and General Counsel. This joint training has been designed to increase decisional consistency between adjudicators at all levels of appeal. Since implementation of this joint training, the rate at which OMHA ALJs reverse decisions from lower levels of appeal has decreased from 63.2 percent in 2010 to their current rate of 43.0 percent, reflecting a more consistent application of policy at all levels.
- ***In Service Training Days*** were added to the training curriculum at OMHA in 2013 to provide critical adjudicatory and administrative training to all employees simultaneously via video-teleconference.
- ***OMHA's Quality Assurance Program*** assesses adjudicatory compliance with procedural requirements and adjudicative norms, identifies trends (both procedurally and substantively) encountered in the adjudication of Medicare appeals and disseminates the lessons learned as part of OMHA's continuing education program. Although OMHA recognizes that decisions of the Medicare Appeals Council are not precedential, we have implemented an enhanced, searchable database of decisions by the Medicare Appeals Council for use by our adjudicators.
- ***Settlement Conference Facilitation Pilot*** uses alternative dispute resolution techniques to resolve multiple appeals filed by a single appellant without hearing. OMHA attorneys, who have been trained in mediation techniques, facilitate a settlement conference between an individual appellant and CMS representatives.
- ***Statistical Sampling Pilot*** allows appellants with qualifying appeals to choose to have their claims adjudicated using statistical sampling and extrapolation and would allow for the resolution of large numbers of claims based upon resolution of a statistically valid sample.

- **OMHA Case Processing Manual (OCPM)** incorporates best practices in case processing and establishes a standardized business practice in all our field offices. The phased release of this manual started in February, 2015.

Just to highlight one of the administrative initiatives listed above, OMHA has implemented the Settlement Conference Facilitation Pilot using existing staff, budget, and regulatory authorities. Although new to the Medicare appeals process, mediation is a common means of resolving disputes throughout the judicial and administrative processes of government. To date, OMHA's settlement conference facilitators have resolved over 1,000 appeals during this extremely limited pilot. This represents the average productivity of an entire ALJ team working for a full year. It is also important to note that because these appeals are resolved by settlement of the underlying dispute, there is no possibility of further appeal to the DAB.

REQUEST NEW RESOURCES TO INVEST AT ALL LEVELS OF APPEAL TO INCREASE ADJUDICATION CAPACITY AND IMPLEMENT NEW STRATEGIES TO ALLEVIATE THE CURRENT BACKLOG

The 2016 President's Budget recognizes that even after efficiencies have been obtained through the administrative actions discussed above, significant additional funding will be required in order for OMHA to handle the number of appeals reaching the third level.

The 2016 President's Budget funds increases in adjudication capacity at OMHA by increasing its current budget of \$87.3 million to \$270 million. The President's Budget proposes three sources for this funding—\$140 million from OMHA's discretionary appropriation, \$125 million from recoveries resulting from the Recovery Audit program, and \$5 million (estimated) from new filing fees. The latter two funding mechanisms are dependent upon passage of legislation which is included in the President's Budget. This additional funding would provide for the addition of 119 new ALJ teams and 82 Medicare Magistrates and increase OMHA's yearly adjudication capacity from 77,000 appeals per year to approximately 278,000 appeals per year. The President's Budget assumes that appeal process reforms in the nature of those listed below will be enacted which will allow OMHA to implement alternative adjudication models at lesser cost and to receive partial funding of its administrative costs from recovery audit reimbursements and filing fees. The President's Budget also assumes that reforms will slow the growth in the rate of appeals reaching OMHA.

PROPOSE LEGISLATIVE REFORMS THAT PROVIDE ADDITIONAL FUNDING AND NEW AUTHORITIES TO ADDRESS THE APPEALS VOLUME

The significant increase in adjudication capacity at OMHA is dependent upon the enactment of the appeal reforms contained in the President's Budget.

- **Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use RA Collections.** This proposal would expand the Secretary's authority to retain a portion of Recovery Audit (RA) program recoveries for the purpose of administering the recovery audit program and will allow RA program recoveries to fully fund the appeals process for RA related appeals at the OMHA and the DAB.
- **Establish a Refundable Filing Fee.** This proposal would institute a refundable per claim filing fee for providers, suppliers, and Medicaid State Agencies, including those acting as a representative of a beneficiary, at each level of appeal. Appeals filed by beneficiaries or representatives of beneficiaries other than providers, suppliers, and Medicaid State Agencies would be exempt from the fee. Fees will be returned to appellants who receive a fully favorable determination. Under current law, there is no administrative fee paid to the adjudicating entity for filing an appeal. A filing fee would encourage those who frequently file to more carefully assess the merits of their appeals before filing.
- **Sample and Consolidate Similar Claims for Administrative Efficiency.** This proposal would allow the adjudication of large numbers of appeals through the use of sampling and extrapolation techniques without appellant consent. Additionally, this proposal would authorize the consolidation of similar appeals into a single administrative appeal at all levels of the appeals process for purposes of adjudicative efficiency. This provision would also require that all appeals that were included within an extrapolated overpayment or were consolidated previously would remain a part of the extrapolated or consolidated file on appeal.

- ***Remand to Redetermination Level upon Introduction of New Evidence.*** This proposal would require remand of a Medicare appeal to the first level of review at CMS when new documentary evidence is submitted into the administrative record at the second level of appeal or above. The proposal would include exceptions to mandatory remands if the basis for the submission is that new evidence was provided to the lower level adjudicator but erroneously omitted from the record, or an adjudicator denies an appeal on a new and different basis than earlier determinations. This proposal provides a strong incentive for all evidence to be produced early in the appeals process and to ensure the same record is reviewed and considered at the second and subsequent levels of appeal.
- ***Increase Minimum Amount in Controversy for ALJ Adjudication of Claims to Equal Amount Required for Judicial Review.*** This proposal would increase the minimum amount in controversy required for adjudication by an ALJ to the Federal district court amount in controversy requirement (\$1,460 in 2015). It would also clarify the circumstances under which claims can be aggregated to meet the amount in controversy limit.
- ***Establish Magistrate Adjudication for Claims with Amount in Controversy Below New ALJ Amount in Controversy Threshold.*** This proposal would allow OMHA to use attorney adjudicators to resolve those appeals that meet the current ALJ amount in controversy threshold (\$150 in 2015) but fall below the amount currently required to file an appeal in federal district court (\$1,460 in 2015), reserving ALJs for development of a record in more complex cases involving higher amounts in controversy, which have the potential for appeal to federal district court. Decisions of a Medicare Magistrate could be appealed to the DAB, but would not meet the amount in controversy required to be appealable to federal district court.
- ***Expedite Procedures for Appeals with No Material Fact in Dispute.*** This proposal would allow OMHA to issue decisions without holding a hearing when there is no material fact in dispute and the decision is governed by a binding authority. These cases include, for example, appeals in which Medicare does not cover the cost of a particular drug or the ALJ cannot find in favor of an appellant due to binding limits on authority. This proposal would increase the efficiency of the Medicare appeals system and result in faster adjudications of appeals at the ALJ level of appeal.

INTERDEPENDENCY OF PROPOSALS

The President's Budget maximizes adjudication capacity at OMHA by incorporating appeals process reforms that allow for the utilization of less expensive adjudication models for some appeals. For example, OMHA estimates that the proposed Medicare Magistrate program would fund the adjudication of approximately 82,000 appeals annually at a cost of \$27 million. Funding the same 82,000 appeals using the existing ALJ process would be almost twice as expensive at \$52 million. Full implementation of the Medicare Magistrate program is dependent upon two legislative proposals currently in the President's Budget—the Increase Minimum Amount in Controversy and the Medicare Magistrate proposal. Similarly, if authorizations are not passed allowing OMHA to receive reimbursement for the administrative costs of adjudicating recovery audit appeals and to institute filing fees, its available resources would be cut in half and its projected disposition capacity would be similarly reduced.

CONCLUSION

OMHA is privileged to have an extremely dedicated workforce of both ALJs and staff who remain committed to processing Medicare appeals that are both timely and reflect the highest quality of decision making. The Department continues to work to address the backlog of pending appeals and to appropriately resolve disputed claims at earlier levels of the appeals process. However, it has become apparent that administrative initiatives which are possible within current budget authority and the existing statutory framework are insufficient to close the gap between workload and resources at OMHA. The Department is committed to bringing these efforts and the resulting appeal workload into balance and believes that the proposals contained in the 2016 President's Budget will provide additional authorities which will enable us to begin to restore that balance. With that goal in mind, OMHA continues to work with departmental leaders to develop comprehensive solu-

tions to its growing workloads and looks forward to working with this committee and our stakeholders to develop and implement these solutions.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. NANCY J. GRISWOLD

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. Providers report that the use of different appeals numbers at various levels of appeal is confusing and hampers efficient tracking. Might you consider implementing a uniform docketing system across various levels of appeal?

Answer. The Office of Medicare Hearings and Appeals (OMHA) is the third of four levels of appeal within HHS for Medicare claims appeals, and currently uses the Medicare Appeals System (MAS) for case management. MAS is also currently used by some Medicare Administrative Contractors (MACs) for level 1 appeals, and all Qualified Independent Contractors (QICs) for level 2 appeals. MAS assigns a new unique appeal number for each new level of appeal. Changing the programming to repurpose the same appeal number would be costly and compete with other essential upgrades to the system in a resource constrained environment. However, OMHA is exploring the possibility of repurposing the level 2 appeal number for level 3 appeals when the OMHA Electronic Case Processing Adjudication System (ECAPE) is implemented.

Question. Although the Office of Medicare Hearings and Appeals did not oversee the CMS Global Settlement Offer because it was a CMS initiative, the outcome of it directly affected your office. Do you know how many claims have been dismissed pursuant to CMS's Global Settlement Offer? In your opinion, did this make a dent in the appeals backlog?

Answer. HHS is still in the process of verifying and completing the review of the claims submitted for administrative settlement. The Centers for Medicare and Medicaid Services (CMS) hospital appeals settlement initiative will have a substantial effect on the number of appeals pending before OMHA Administrative Law Judges (ALJs), as well as those awaiting assignment. As appeals are verified as being appropriately included in the settlement, they are dismissed by OMHA and removed from the count of pending appeals. We anticipate that we will have more precise numbers in the near future.

Question. There has been some controversy over whether the correct Medicare policy standards are being applied and whether ALJ rulings have been consistent across the board. The Administration's Fiscal Year 2016 budget request provides for increased ALJ training on Medicare policy. This is an issue that the Office of Medicare Hearings and Appeals has been working on. What progress can you report in this regard?

Answer. In July 2010, OMHA implemented its Judicial Education Symposium (JES) program, which is an annual series of in-depth continuing education events on Medicare law and policy that all ALJs are required to attend. The JES provides consistent training to OMHA ALJs on Medicare policy issues and coverage standards. In addition, in February 2011, OMHA implemented a formal week-long training program for all new ALJs hired by OMHA focused on Medicare law and policy, and the administrative appeals processes. OMHA delivered the fifth new ALJ training session in May of 2015. Finally, in 2013, OMHA implemented a monthly "In-Service" program of seminars and training sessions for on board ALJs, also focused on Medicare law and policy, and the administrative appeals processes.

OMHA has partnered with Departmental experts from CMS, the Food and Drug Administration (FDA), the Office of Inspector General (OIG), the Office of the General Counsel (OGC), and the Departmental Appeals Board (DAB) to deliver JES sessions, and other continuing education events. The joint training has been designed to increase decisional consistency among OMHA ALJs through education by policy experts. Since implementation of the JES, new ALJ training, and the In-Service programs, OMHA has seen significant change in the rate at which ALJs reverse decisions from lower levels of appeal. The reversal rate has decreased from 63.2 percent in FY 2010 to the current rate of 43.0 percent.

Question. What thoughts do you have on the President's budget proposals and whether they will make the differences purported, or do we need to continue to also explore other legislative alternatives?

Answer. The legislative proposals, taken together with the additional resources requested in the FY 2016 President's Budget, are instrumental to reducing the appeals backlog and setting the framework for bringing the Medicare appeals process into balance going forward. OMHA believes that instituting a refundable filing fee will encourage more providers, suppliers, and other non-beneficiary appellants to consider the merits of their claims before filing appeals, which will address some of the demands currently being placed on the appeals by appellants who do not appear to consider the merits of their claims before filing appeals. Providing authority for case consolidation and the authority to group claims together to allow for a single decision on multiple claims, would ensure future appeals are handled more efficiently. Also, the addition of 119 ALJs and 82 Medicare magistrates will increase OMHA's decision-making capacity from 77,000 appeals per year to approximately 278,000 appeals per year, which will make a significant difference in addressing the backlog and establishing a sustainable model for the timely adjudication of future appeals. If the case consolidation provision is given retroactive application and applied to pending appeals, it will further help address the backlog by providing a tool to more efficiently group pending appeals for adjudication. These proposals work in tandem and are dependent on one another to have the projected impacts.

While enacting the proposals is a critical first step, the Department continues to pursue additional measures that may be taken at a legislative or regulatory level. OMHA received 92 responses to a November 5, 2014, Request for Information from program stakeholders with suggestions on how to improve the appeals process. The Department is currently reviewing those suggestions. In addition, a Departmental inter-agency workgroup was established in 2013, which includes leaders from the agencies involved in the Medicare claims appeals process (CMS, OMHA, and DAB). This inter-agency group reviewed the appeals process and developed a series of initiatives that both OMHA and CMS are implementing to reduce the current backlog of pending appeals and the number of appeals that reach OMHA, and continues to meet on a regular basis.

Question. Finally, as we continue to develop our statutory response to these issues, what would be the one thing that you would change to improve the flow of the appeals process?

Answer. Adding adjudicatory flexibilities to the statutory appeals framework would have the greatest impact on the flow of the appeals process. Specifically, alternate adjudicators (Medicare magistrates) could be authorized to make decisions on those claims which have no possibility of reaching federal court due to the low amounts in controversy. Other flexibilities, such as summary disposition authority when no material facts are at issue and the outcome of the appeal is mandated by a binding authority, and the ability to decide appeals using statistical sampling and extrapolation techniques, would add efficiencies to the appeals process at all levels. These changes alone would improve the flow of cases from one level of appeal to the other.

The existing Medicare claims appeal structure is a complex process controlled by a fixed statutory and regulatory framework. Increased receipts have stressed the appeals process and there are limited adjustments OMHA can make to adequately accommodate the influx of appeals. For example, the current statutory and regulatory framework requires that all level-three appeals be adjudicated by an Administrative Law Judge, and all appeals must be adjudicated independently, even in repetitive circumstances such as ongoing, monthly rentals of durable medical equipment (DME). If Medicare providers and suppliers continue to avail themselves of their right to appeal adverse determinations in record numbers, adjudicators would benefit from additional authorities that allow for more efficient adjudication as proposed in the FY 2016 President's Budget, such as the Medicare magistrates. The measures proposed in the FY 2016 President's Budget would create a more flexible (and cost-efficient) appeals process and allow OMHA to become more nimble and to more quickly respond to rising workloads.

Question. Recent data from OMHA indicate that a large portion of the dollars recouped by RACs from Part B providers, as much as 50%, is coming from patient care providers of prosthetics and orthotics—artificial replacement limbs and bracing—but this group of health professionals account for less than 0.5% of Medicare expenditures. The unit cost of replacement limbs is relatively high so RACs, which are incentivized by percentage of funds they recoup, are focusing on this group even though data show that these limb providers have the highest success ALJ appeal rate of any Part B providers. Are there any controls on RACs from concentrating

excessively in one area simply because returns per efforts expended in the short run may be substantial?

Answer. OMHA defers to our colleagues at CMS as the agency that oversees the Recovery Auditor program. In order to make certain that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency within HHS, reporting directly to the Secretary. Accordingly, OMHA operates under a separate appropriation and is both functionally and fiscally separate from CMS.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. For the last couple of years, there has been constant controversy over the battle between Medicare providers, especially hospitals, and recovery audit contractors (RACs). When an appeal is heard, someone wins and someone losses, but there's no public scorekeeping of wins and losses. We believe that open accounting could cut down on frivolous findings by RACs, frivolous appeals by providers, and lackadaisical rulings from the reviewers.

There is a value in transparency when government is engaged in the people's business. In this case, the appeals process is in desperate need of transparency. Regularly, I will have providers tell me they win 90% of their appeals. Then minutes later, I will get visits from auditors who tell me they are winning 90% of their appeals. Clearly, those numbers do not add up.

The appeals process would benefit from an open and transparent accounting of appeals outcomes. If we are concerned about frivolous findings against providers, frivolous appeals of auditor findings, and reviewers not devoting adequate consideration to the policy issues, transparency would shine a light on all parties to the process.

Is there any reason you can think of that we should NOT publish, in the aggregate, the appeals outcomes, essentially wins and losses by provider and auditor at your level of the appeal process?

Answer. OMHA is committed to data transparency and continues to examine what data are available and relevant to our stakeholders. However, OMHA appeal outcomes represent only the third of four levels of administrative appeal within HHS, so these data would provide only a limited snapshot of the larger picture. For example, an ALJ decision may be subject to further review by the Medicare Appeals Council if the appellant files a request for review, CMS (or its contractors) refers the case to the Council for review, or the Council decides on its own motion to review the ALJ decision.

In addition, we note that the primary challenge for OMHA in providing this type of information is the availability and structure of the data in our version of the Medicare Appeals System (MAS) case management system, which is necessarily focused on data related to case processing at the ALJ level of appeal. Aggregate provider appeal outcome data can most easily be expressed in relation to a Medicare Part (such as Part A or Part B), or a category of services (for example, inpatient hospital services, physicians, durable medical equipment suppliers, skilled nursing facilities, and ambulance companies). We do not believe that our data currently identify the underlying auditor associated with an appeal.

Question. Is there any reason you can think of that we should NOT publish, in the aggregate, the appeals outcomes by the specific ALJs so we can look at them comparatively?

Answer. While there is no statutory impediment to publishing these data and OMHA is considering doing so in the near future, OMHA believes that ALJ outcome data may be subject to misinterpretation because large numbers of appeals involving a single or similar issue may be assigned to an ALJ. The decision on the issue may then have a significant impact on the ALJ's outcome statistics. These data anomalies may increase as OMHA works through its backlog and assigns larger groups of similar cases to ALJs. There is also a potential issue with comparative statistics having some influence on decision outcomes, if ALJs feel pressure to achieve outcome statistics within a specific range. Additionally, publishing an individual ALJ's outcomes could result in appellants attempting to forum shop by seeking recusals from ALJs who they believe may not rule in their favor based on outcome data, even though the ALJ is acting impartially.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. Rural providers often operate on the margins and these types of delays leave providers in limbo for far too long. At the ALJ level is there any consideration being given to expedite the appeals of small or rural providers' appeals?

Answer. Currently, OMHA prioritizes appeals filed by beneficiaries, who are our most vulnerable appellants. These appeals, which include Part D expedited appeals and other beneficiary-appellant appeals—including pre-service appeals arising under Part C, receive first priority at every stage of the appeals process; they are immediately assigned to an ALJ, and prioritized for hearing and decision by the assigned ALJs. Provider, supplier, and other non-beneficiary appeals are assigned and heard in the order in which they were received. We have considered additional prioritization of our workload as a result of suggestions received from appellants in response to our Request for Information. However, additional prioritization is problematic for a number of reasons. First, OMHA's case tracking system does not have a way to identify small or rural providers. Second, in addition to rural or small providers, there have been multiple requests for prioritization of other workload. We have also received requests to prioritize high dollar value appeals and appeals in which large overpayments are being recouped. We recognize that processing delays have a significant impact on providers and suppliers regardless of the number of claims at issue or the amount in controversy, but since prioritizing one group will necessarily be at the expense of another, additional prioritization is not advisable at this time.

We also note that where an appellant has submitted a request for hearing following a Medicare Part A or Part B Qualified Independent Contractor (QIC) reconsideration, the appellant may request an escalation to the next level of review (the Medicare Appeals Council) if the ALJ does not render a decision within 90 days after a complete request for hearing was timely filed with OMHA. This "escalation" process was built into the statute to ensure that appellants can continue to pursue their appeals if the ALJ is unable to adjudicate an appeal within the 90-day time-frame envisioned by Congress. More information on the escalation process is available on the OMHA website (www.hhs.gov/omha), under the "Coverage and Claims Appeals" tab.

Question. A 2012 Health and Human Services (HHS) Office of Inspector General (OIG) Report stated that in FY 2010, Administrative Law Judges (ALJ) reversed prior-level decisions and ruled fully favorable or partially favorable to the appellant over 60 percent of the time. How can we reform the appeals process to ensure that there is greater continuity in decisions at both the ALJ and the prior-levels in order to give providers more predictability in the audit and appeals process?

Answer. The difference in outcomes across appeal levels is attributable to a number of factors, including: the introduction of new and additional evidence, the opportunity for an appellant to orally present his or her testimony at the ALJ level of appeal, the non-binding authority of informal CMS manuals and other program guidance on ALJs, and the winnowing of appeals as some appellants select only their most meritorious claims for appeal. These occurrences are a natural consequence of the Medicare appeals system as established by Congress, and are not necessarily attributable to a lack of training or knowledge of Medicare policy on the part of OMHA ALJs.

Generally, under the current appeals structure, CMS or its contractors may also refer ALJ decisions or dismissals to the Medicare Appeals Council for "own motion review" if they believe that an ALJ decision contains an error of law material to the outcome of the claim or presents a broad policy or procedural issue that may affect the public interest.

CMS, OMHA, and the Medicare Appeals Council communicate at the leadership and staff levels on a variety of appeals process coordination matters. When there are large numbers of appeals in a given area that implicate a current or potential policy interpretation variance, the general matter can be raised and discussed, and appropriate action on the general issue taken, such as conducting additional training with OMHA and Medicare Appeals Council staff.

In addition, as reflected in the response to the Chairman's third question, OMHA has developed multiple training and continuing education resources for OMHA ALJs, and OMHA has seen significant change in the rate at which ALJs reverse decisions from lower levels of appeal. The reversal rate has decreased from 63.2 percent in FY 2010 to the current rate of 43.0 percent.

Question. Information provided in the same 2012 HHS OIG report stated there were concerns about consistency in individual ALJ approval and rejection rates. Approvals ranged from 18 to 85 percent in FY 2010. What can Congress do to again provide more consistency in ALJ rulings that would in effect provide greater certainty at all level of appeals?

Answer. ALJs must act within the scope of legal authorities and give deference to local coverage determinations and CMS program guidance. However, each ALJ has qualified decisional independence under the Administrative Procedure Act (APA). Because individual adjudicators are applying the law and coverage policy to facts (which vary from case to case), some level of disparity in outcomes is inherent in the adjudication process. Although every effort is made to ensure consistent decision making, differences in decisional outcomes occur between adjudicators at the ALJ level, as well as between claims reviewers at the lower levels of the appeals process.

While some variances among adjudicators will continue, OMHA has made significant efforts to maximize consistency. OMHA works with CMS to deliver expert-led training sessions on Medicare policy and its application to common claims scenarios such as emergency medical treatment, non-emergency ambulance transport, billing and coding initiatives, and determinations of inpatient admission status. CMS also provides regular updates to OMHA adjudicators as it adjusts or clarifies existing policies, such as the Two-Midnight Rule for inpatient hospital stays and continuation of care issues resulting from *Jimmo v. Sebelius*. These sessions have been extremely instructive for adjudicators and have led to greater consistency among appeal levels. As a result of these and other training initiatives, OMHA has seen a marked decrease in the rate at which ALJs reverse decisions from lower level adjudicators, down from 63.2 percent in FY 2010 to the current level of 43.0 percent.

One area where standardization is possible is the OMHA business process. This is one way to ensure that ALJs are applying the relevant authorities consistently and availing themselves of the most efficient means to process an appeal. Standardization also provides a more uniform experience for appellants nationwide, regardless of where or by whom their appeal is heard.

OMHA's commitment to business process standardization is evidenced in two initiatives: the OMHA Case Processing Manual (OCPM) and the Medicare Appeals Template System (MATS). OMHA launched its new manual internally in March 2015, documenting agency policy and incorporating best practices from the field. The OCPM will increase efficiency in case processing and can be updated to allow for continued innovation. It also increases the flexibility of support staff to move between judge teams. In addition, OMHA has developed MATS, a sophisticated document generation system that will improve the quality and consistency of OMHA decisions and documents and increase overall efficiency. First rolled out to field offices in March 2014, MATS standardizes and streamlines decision and document drafting and is being updated on a rolling basis. These templates do not decide cases, but can be used to guide analysis and standardize language articulating the applicable law and policy. The system prevents common document errors by pulling data from our electronic case management system and populating that data directly into documents, which is especially important in such a high volume environment.

These initiatives are a foundation for a more consistent and efficient process going forward and with the funding and authorities proposed in the FY 2016 President's Budget, Congress can ensure that resources are available to continue and further these standardization efforts.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

Question. Between Fiscal Year 2009 and Fiscal Year 2014, the number of appeals received by the Office of Medicare Hearings and Appeals increased by more than 1,300 percent. What are the most significant contributing factors to the changes in the volume of appeals?

Answer. Several factors have contributed to the growth in Medicare Appeals. In FY 2010, OMHA started receiving appeals from the permanent Recovery Audit program, which represented a new source of appeals workload. During this same time period, OMHA experienced concurrent growth in the traditional appeals workload that OMHA had been receiving since it began operations in 2005; between FY 2009 and FY 2014 OMHA's traditional workload alone increased by 543%. In FY 2011 and FY 2012, OMHA also saw an increase in the number of appeals filed by Med-

icaid State Agencies related to the treatment of dual-eligible beneficiaries (beneficiaries who are enrolled in both Medicare and Medicaid). Finally, the increase in workload may be partially attributable to increases in Medicare enrollment as the “baby boom generation” and more individuals determined to be disabled under the Social Security disability program become Medicare-eligible, which may be increasing the number of beneficiaries utilizing Medicare services and resulting in a higher universe of potential disputes.

Question. How would annual judicial education training address some of the issues associated with the timeliness and predictability of the appeals process for both providers and beneficiaries going through an appeal?

Answer. OMHA’s annual Judicial Education Symposium provides an opportunity to train adjudicators on emerging issues in Medicare coverage policy and frequently involves experts from CMS as presenters. In addition, OMHA implemented a formal, mandatory training program for all new ALJs that focuses on Medicare law/policy and adjudicative business processes.

OMHA is working toward providing appellants with a more uniform and predictable experience with the appeals process by standardizing our business process through the creation and issuance of the OMHA Case Processing Manual (OCPM). OMHA launched this manual internally in March 2015, and plans to provide public notice via the Federal Register and then post the manual on our public website. The OCPM documents agency policy and incorporates best practices from the field. It will increase efficiency in case processing and can be updated to allow for innovation. This initiative will help to ensure that judges are applying the relevant authorities consistently and availing themselves of the most efficient means to process an appeal. This standardization also provides a more uniform experience for appellants nationwide, regardless of where or by whom their appeal is heard. It also increases the flexibility of support staff to move between judge teams.

Question. How have the alternative dispute resolution techniques been received by providers seeking to appeal decisions? Are a certain subset of providers utilizing this option? Have any lessons emerged from the Settlement Conference Facilitation Pilot that could be drawn upon as we continue to look for ways to address concerns with the current state of the audit and appeals processes?

Answer. When OMHA offered appellants the option to resolve pending appeals through the OMHA Settlement Conference Facilitation pilot, we did so in a limited capacity due to staffing and resource limitations. As it currently exists, the pilot is limited to appellants who filed requests for hearing on a Medicare Part B Qualified Independent Contractor (QIC) reconsideration during a particular period of time and that met certain other criteria. As such, the appellants who have participated thus far have been primarily Part B suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and outpatient therapy. As of May 13, 2015, OMHA received 24 requests involving a total of 4,273 claims to participate in the pilot. Currently, eight requests are pending. Of the remaining 16 requests, 6 requests resulted in a settlement of a combined 1,574 appeals involving 1,617 claims. OMHA rejected five for failure to meet eligibility criteria, three did not result in settlement between the parties, and CMS declined to participate in two.

OMHA is encouraged by the results of the initial pilot, which, as of May 2015, has resolved the equivalent of one-and-a-half ALJ teams’ annual workload (1,500 appeals), at a considerable cost savings to OMHA. The primary lesson learned from this pilot is that the initial eligibility criteria may have been too restrictive, as many other appellants have informally expressed an interest in being able resolve their appeals through an alternative dispute resolution process.

Question. If the Office of Medicare Hearings and Appeals were to move forward with the concept of allowing adjudication of large numbers of appeals through the use of sampling and extrapolation techniques, how would this be done in a statistically sound manner?

Answer. OMHA would manage this effort through a current contract that provides access to qualified, independent statistical experts. The OMHA experts would ensure sampling conducted at the ALJ level conformed to the standards outlined in the CMS Program Integrity Manual, which provide instructions to CMS contractors on the use of statistical sampling to calculate and project overpayment amounts to a universe of claims.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RESOURCES NEEDED TO IMPROVE THE APPEALS SYSTEM

Question. During the hearing you shared that the current adjudication capacity of the Office of Medicare Hearings and Appeals (OMHA) is approximately 77,000 appeals. You also shared that in FY 2014 alone, your Office received approximately 474,000 appeal requests. These requests are in addition to the pervasive backlog already existing at your level of review.

Simple math makes it quite clear that this type of capacity falls severely short. While I appreciated your testimony regarding efforts that have increased adjudication capacity within your current resources, it sounds as though many of these concepts have been exhausted. This year, the President's budget suggested that an additional \$127 million be appropriated to the Department of Health & Human Services, OMHA, to address the growing backlog of appeals.

Can you please share how your office would utilize the \$127 million, if so appropriated, to decrease the backlog?

Answer. The funding and legislative proposals requested in the FY 2016 President's Budget include both discretionary budget authority and program level funding from proposed legislation, totalling \$182.6 million above the FY 2015 enacted level. This request positions OMHA to process more Medicare appeals by providing resources to establish six new field offices and expand two current field offices to the full complement of 18 ALJ teams. These offices will support 119 new ALJ teams nationwide, compared with the projected 77 teams on board by the end of FY 2015. These new teams will collectively increase output by 119,000 additional appeal dispositions a year.

The additional funding also supports several HHS and OMHA initiatives to address the workload by alternate adjudication methods such as 82 Medicare Magistrates and additional attorney adjudicators and settlement conference facilitators.

Question. How many appeals could be processed annually if this Congress were to adopt the recommendations of the President?

Answer. OMHA's annual adjudication capacity would increase by 261% (from 77,000 appeals per year to approximately 278,000 appeals per year) with just the increase in ALJ teams and the establishment of Medicare Magistrates. It is anticipated that other alternative adjudication methods such as expansion of OMHA's Settlement Conference Facilitation pilot will further increase adjudication output.

Question. How would the President's policy recommendations otherwise impact the incoming requests for appeal?

Answer. It is anticipated that the legislative proposals in the FY 2016 President's Budget will have an impact in reducing the number of new appeals entering the system. For example, the institution of a refundable filing fee at each level of appeal should encourage providers to more carefully assess the merits of their appeals before filing.

THE USE OF MEDICAL EXPERTISE TO ADJUDICATE MEDICALLY COMPLEX CASES

Question. Anecdotally, I have been informed that cases involving "medical necessity," or those cases which require significant clinical review and input to effectuate, are most frequently subject to higher level appeal requests. I also understand that such cases are timely to review, and at the lower levels of appeal are reviewed by a clinician, such as a nurse and/or physician.

Given that the majority of your staff do not have clinical backgrounds or expertise, can you please walk through how such cases are typically handled under the current process?

Answer. The cases that are appealed to and processed by OMHA include a variety of issues. Many issues do not require a clinical background or expertise to properly adjudicate because they involve appeals of technical denials for services that are not covered or appeals where regulatory guidelines or policies set forth criteria that establishes medical necessity, and therefore coverage. These types of appeals require the application of a specific set of policies or rules to a specific set of facts to establish coverage. In cases where medical necessity is not well defined by either a specific regulation or policy, OMHA adjudicators have the opportunity to obtain clinical opinions regarding medical necessity. Options for obtaining clinical opinions include adjudicator review of the medical opinions from the medical review panel at the

lower level of appeal (in the QIC's decision and administrative record); allowing expert medical opinion testimony by the appellant or any other party (including CMS contractors if they appear as a party or participant); and review of medical records and testimony by an independent medical expert at the request of OMHA. OMHA maintains a contract to ensure that expert testimony is available to its adjudicators if necessary. These independent experts are compensated for their testimony out of OMHA's budget and are independent of CMS or any other parties. Therefore, in the cases where clinical expertise is required, OMHA adjudicators have the opportunity to obtain clinical opinions regarding medical necessity and to weigh the opinions in light of the entire evidence in the record.

Question. Do you think that it may be useful to uniformly require adjudicators at OMHA to seek the clinical opinion of an independent expert in making such appeal decisions? Why or why not?

Answer. As discussed above, OMHA adjudicators have the opportunity to obtain several clinical opinions regarding medical necessity. However, a significant number of appeals adjudicated by OMHA do not require specific clinical expertise or opinion, but rather are legal decisions. Requiring independent expert opinions in all appeals regardless of need would significantly increase the cost and time required to adjudicate OMHA appeals. The best use of OMHA's resources is to make decisions concerning the need for clinical opinions on a case by case basis.

Question. Do you believe the use of a clinical expert could increase consistency and decrease the potential for variation? Why or why not?

Answer. Anecdotally, OMHA experience is that there is as much variation in the opinions of clinical experts as there is within OMHA adjudicators; thus, we are not confident that mandating the use of clinical experts would increase consistency or decrease the potential for variation. As mentioned previously, OMHA has maintained a clinical expert witness contract since its inception, and OMHA adjudicators have used significant numbers of clinical expert witnesses in a variety of appeals over the years. It has been OMHA's experience that there were some experts who were more likely to give favorable testimony to appellants, while others were more likely to offer favorable testimony to support the denial, for similar facts. In these cases OMHA adjudicators often act to increase consistency and decrease the potential for variation by assigning appropriate weight to the clinical expert opinions before them, after considering the entire record and clinical expert testimony from all parties/participants. A significant number of appeals OMHA processes do not require specific clinical expertise, and therefore would not benefit from the use of a clinical expert.

IMPROVING EFFICIENCY THROUGH ELECTRONIC CASE FILES AND INTERCONNECTIVITY

Question. During the hearing, Tom Naughton of Maximus Federal Services explained that if a claim the QIC has reviewed is then appealed to OMHA under the current appeals system, the QIC employees must print out their electronic copy so that the OMHA may perform the third level of review using a paper copy. I also understand that OMHA is diligently working towards an electronic case file system—expected to be released next spring—entitled the *Electronic Case Adjudication and Processing Environment*, or “ECAPE.” I commend your efforts and look forward to its timely release.

The testimony also indicated that this type of interconnectivity is currently limited, but could assist with both providing transparency for the appellant regarding their appeal's status, as well as assurances to the reviewer that the case file is unaltered and complete.

Once the ECAPE system is activated, do you anticipate that all levels of review will be electronically interconnected so that case files may be safely and electronically accessed and/or transmitted at all review levels?

Answer. Adjudicators at levels 1 and 2 of the Medicare Parts A and Part B claims appeals process currently use the electronic case files in the Medicare Appeals System (MAS). ECAPE will interface with MAS, allowing level 3 adjudicators secure, electronic access to claims files. At this time, the Medicare Appeals Council does not use MAS for case management but is exploring the use of electronic records.

Question. Do you think the use of electronic case files will help OMHA to monitor the incidence of new evidence that is submitted at the third level of review?

Answer. Yes, ECAPE will include the capability to track the submission of new evidence at level three.

QUESTIONS SUBMITTED BY HON. CHARLES E. SCHUMER

Question. The New York State Office of the Medicaid Inspector General has seen alarming increases in the percentage of Medicare appeal denials as well as substantial increases in the time to obtain decisions. At the first two levels of appeal, Medicare contractors are denying over 99% of the appeals. For ALJ's the 90 day statutory requirement is not being met in over 99% of cases. The current wait is averaging 562 days and will continue to grow since OMHA has announced that they have suspended the assignment of new appeals for 2 years. Overall, there are currently 124,246 episodes backlogged at the ALJ level and for appeals that have actually reached a final decision, we are averaging 1,135 days from the Medicaid date of service. Despite seminal decisions in federal district courts that support the appellants, we are seeing favorable decisions rates by the ALJs trend downward—from 26% for FFY 2008 cases to 16% for FFY 2010 cases. Under the demonstration project where third party arbitration services were used instead of OMHA's ALJs, favorable decisions were granted in 69% of the cases.

The Office of Medicare Hearings and Appeals (OMHA) has yet to offer a feasible administrative remedy to State Medicaid agencies (sampling, mediation). Further, State Medicaid agencies are excluded from participating in some of the offered remedies.

Will the OMHA be willing to discuss the potential for a revised demonstration model with the State of NY?

Answer. The goal of this demonstration would be to reduce the administrative burdens on both the current Medicare appeals system and its stakeholders. More importantly, assist with clarifying coverage guidelines related to home health services for dual eligible beneficiaries thus reducing the frequency of misdirected claims/appeals.

While OMHA does not have demonstration authority or authority to settle appeals on its own, OMHA has been working with CMS and a limited number of appellants in certain circumstances through our Settlement Conference Facilitation pilot. As we gain experience with the Settlement Conference Facilitation pilot, we will consider whether we can use this experience to improve the appeals process for Medicaid State Agencies.

Question. You testified in July that more than 800,000 appeals were pending. What is that status of the backlog today, following the completion of the CMS settlement, and how long will it take to clear the remaining backlog? What will you do to prevent the backlog from rising again?

Answer. HHS is in the process of verifying and completing the review of the claims submitted for administrative settlement. As appeals are verified as being appropriately included in the settlement, they will be dismissed by OMHA and removed from the count of pending appeals. We anticipate that we will have more precise numbers in the near future. As of March 31, 2015, OMHA had 870,000 appeals pending.

Any projections related to reducing the backlog of appeals must take into consideration the projected impact of the administrative initiatives underway and the full adoption of the FY 2016 President's Budget. Because several of the proposals in the President's Budget are designed to appropriately resolve disputes at earlier levels of the appeals process, thus reducing appeal levels at OMHA, a portion of the success of the proposals is dependent upon the way in which appellants respond to the proposed changes. For example, the implementation of a filing fee is designed to provide an incentive for providers to carefully evaluate their claims prior to filing and to appeal only their most meritorious claims to the later levels of the appeals process. The impact of other provisions concerning the way appeals may be aggregated to reach the required amount in controversy for an ALJ hearing and provisions related to early submission of evidence (which would require lower level reviewers to have access to the same information being relied upon at the ALJ level) will also be largely dependent upon appellant behavior. Regardless, there still must be a balance between receipts and capacity to adjudicate incoming appeals without expanding adjudication capacity too rapidly and over building the agency. With the current pause of the Recovery Audit program, there is a projected leveling of receipts, but the end state of annual receipt levels is uncertain. OMHA recognizes that any comprehensive endeavor of this magnitude would be better addressed over several years for fiscal as well as programmatic reasons to ensure resources match what our future annual workloads are likely to require while carefully monitoring the impact of Departmental initiatives and legislative reforms.

Under Secretary Burwell's leadership, the Department has developed an approach to reduce the risk of a future backlog through administrative actions, additional funding, and legislative reforms to mitigate the appeals volume, including initiatives to resolve disputed claims at earlier levels of the appeals process. OMHA, with Departmental support, is committed to bringing these efforts to fruition. The full adoption of the FY 2016 President's Budget will allow OMHA to significantly increase its adjudicatory capacity above its FY 2015 level and will begin to restore the balance between workload and resources going forward.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

RECOVERY AUDIT CONTRACTORS (RACS)

Question. RACs are another tool CMS uses to audit potentially improper payments. The RAC system was permanently established by Congress in 2010, following a 3-year demonstration. RACs are paid on a contingency-fee basis based on their identification of improper payments.

In 2012, RACs returned almost \$2 billion to Medicare. Over half of the funds appeals received by the Office of Medicare Hearings and Appeals (OMHA) are RAC-related. Today, OMHA is funded only by discretionary appropriations.

It seems as though the enormous spike in appeals that has overwhelmed the system is mainly attributable to hospital appeals of RAC determinations.

Judge Griswold—would you support a separate appeals system for those claims? Do you have suggestions for how that could work?

Answer. Because the same coverage rules apply regardless of whether a claim arises from pre-payment or post-payment review, establishing a separate appeals system for Recovery Audit appeals would add complexity and uncertainty to the system and would ultimately be counterproductive. A separate appeals system would also result in greater disparities in outcomes, and would likely confuse appellants. OMHA already hears appeals arising from separate claims/coverage appeals processes for Part A and B appeals; Part C Medicare Advantage appeals; Part D prescription drug appeals. OMHA also hears Medicare eligibility and entitlement appeals arising from the Social Security Administration (SSA), including Part B Late Enrollment Penalties (LEPs) and Income Related Monthly Adjustment Amounts (IRMAAs). Even within these separate appeals processes, differences arise. For example, the first level of appeal for a Part A or B appeal may be conducted by the Medicare Administrative Contractor (MAC), a Quality Improvement Organization (QIO), or the Benefits Coordination and Recovery Center (BCRC). From there, most of the redeterminations (excluding certain QIO medical necessity and appropriateness of setting reviews) have a second level of appeal conducted by a QIC. While most decisions made by a QIC or QIO are appealable to an ALJ, certain decisions, such as QIO Diagnosis Related Group (DRG) coding validations, are not. Introducing a separate appeals process for Recovery Audit appeals would increase confusion, make an already complex appeals system more intricate, lead to greater disparity in decisional outcomes and frustrate the primary goal of streamlining the appeals process.

ADMINISTRATIVE LAW JUDGE (ALJ) APPEAL

Question. In FY 2013, OMHA received more than 654,000 claims. This was up from just under 60,000 in FY 2011. Despite the significant increase in claims, the total number of judges available to hear and decide cases remained the same, at just over 60.

As a response to this increase in claims, OMHA temporarily suspended the assignment of most new requests for ALJ hearings from providers, and HHS has attempted to put in place some reforms to help speed the system along. However, despite the pause in new cases, these delays persist for both beneficiary and provider appeals.

I have heard from both providers and beneficiaries in Ohio who believe that the first and second level of appeals are often a "rubber stamp" of the initial determination, and that very little consideration is given until the ALJ appeal, where it seems that a large percentage of claims are reversed.

Judge Griswold—of those claims that are appealed to the ALJ level, what is the reversal rate for provider-initiated claims? What is the reversal rate for beneficiary-initiated claims?

Answer.

Reversal Rate for Non-Beneficiary-Initiated Claims

FY13 50.5%

FY14 40.0%

FY15 (year to date) 43.0%

Reversal Rate Beneficiary-Initiated Claims

FY13 31.5%

FY14 33.4%

FY15 (year to date) 34.1%

The calculation includes all non-beneficiary appeals instead of only provider requested appeals to account for those appeals that have a requester type other than provider and beneficiary. Reversal rate is the total of Favorable and Partially Favorable dispositions divided by the total appeals with Favorable, Partially Favorable, Unfavorable, and Dismissed dispositions.

MAKING THE SYSTEM MORE FRIENDLY FOR BENEFICIARIES

Question. Despite the fact that the Medicare appeals system was created with beneficiaries in mind, we know that it is providers who file the vast majority of appeals. In 2010, for example, Medicare beneficiaries filed just 11% of the appeals heard by ALJs.

Today, beneficiary-initiated appeals continue to make up a proportionally small percentage of the total number of appeals, but they continue to get lost in the shuffle.

Judge Griswold—what has OMHA done to prioritize beneficiary-initiated appeals? What more can be done to ensure timely review of beneficiary-initiated cases and make the current system more beneficiary-friendly?

Answer. Individual beneficiaries are among the most vulnerable appellants. In 2013, OMHA began prioritizing beneficiary-initiated appeals, and in 2014, established a dedicated mail-stop for beneficiary-initiated appeals, to ensure those appeals are quickly identified and assigned to an ALJ for hearing. OMHA worked with CMS to update lower level appeal instructions to alert beneficiaries to this mail-stop. Our prioritization measures have resulted in beneficiaries getting a decision more quickly. In February 2015, we estimated that the average time to decision for beneficiary appeals decreased from 244.6 days in FY 2013 to 125.0 days in FY 2014 (this calculation does not include Part D expedited appeals, which operate on a much shorter (10-day) time frame). Similarly, the total number of aged beneficiary appeals at the agency has been reduced.

At the beginning of the first quarter in FY 2014, OMHA had 1,620 beneficiary appeals older than 90 days. As of April 26, 2015, OMHA had 358 beneficiary appeals older than 90 days. This figure includes appeals that have been delayed at the beneficiary's request, such as postponing a hearing to accommodate a hospitalization, to obtain a representative/attorney, or to obtain and submit additional records.

Question. Judge Griswold—what can be done to help beneficiaries who filed *before* the prioritization process was put into effect, and have been waiting the longest? How are their inquiries handled if they call 1-800-Medicare?

Answer. If a beneficiary filed a request for hearing and believes that it has not been prioritized, he or she may contact OMHA Headquarters by writing to OMHA Headquarters, 1700 N. Moore St., Suite 1800, Arlington, VA 22209, calling 703-235-0635, or emailing Medicare.Appeals@hhs.gov. Beneficiaries may also contact OMHA using our national toll-free number 855-556-8475.

Question. Judge Griswold—given that beneficiaries are often the most vulnerable appellants and are who the Medicare program is meant to serve, in addition to the fact that beneficiary-initiated appeals represent such a small percentage of overall appeals, would you support maintaining full procedural rights and protections for

them, e.g., not assigning their cases to “Magistrate” ALJs, and not increasing the amount-in-controversy threshold?

Answer. OMHA recognizes the vulnerability of individual beneficiaries and has prioritized beneficiary-initiated appeals to expedite their processing and resolution. In most cases, Medicare beneficiaries and enrollees have already received the item or service that is the subject of a claim or coverage dispute, and the only remaining question is payment responsibility. Only in certain circumstances (e.g., Part D requests for drug coverage, Part C pre-service authorization requests, hospital discharge appeals, and provider service terminations) might provision of an item or service depend on the outcome of the appeal. We continue to prioritize expedited Part D appeals that must be adjudicated within 10 days, as well as pre-service appeals arising under Part C and other beneficiary appellant appeals.

In their current formulation, the legislative proposals contained in the FY 2016 President’s Budget are designed to provide flexibility and additional protection to beneficiary-appellants. For example, beneficiaries would be exempt from the filing fee proposal and the proposal requiring remand to the redetermination level when new evidence is introduced at a later level of appeal. However, we acknowledge that some portion of beneficiary appeals would fall within the proposed changes to the amount in controversy and the Medicare magistrate process. We believe that procedures can be put in place through regulations to balance the impact on the beneficiary population with the efficiencies gained through the magistrate process.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. As the panel has pointed out, the Office of Hearings and Appeals (OMHA) received more than 654,000 claims in FY 2013, up from under 60,000 in FY 2011, which has increased the backlog and average processing time for an appeal’s decision. What do you believe are the primary causes of this dramatic increase in claims? And to follow-up, what are some commonsense, balanced fixes to address the backlog that could help ensure that seniors and their physicians are able to receive and provide needed care?

Answer. The legislative proposals outlined in the FY 2016 President’s Budget will provide the most balanced, effective means of reducing the Medicare appeals backlog, and ensuring that OMHA and other HHS components have the continuing resources to prevent another backlog from developing.

Several factors have contributed to the growth in Medicare Appeals. In FY 2010, OMHA started receiving appeals from the permanent Recovery Audit program, which represented a new source of appeals workload. During this same time period, OMHA experienced concurrent growth in the traditional appeals workload that OMHA had been receiving since it began operations in 2005; between FY 2009 and FY 2014 OMHA’s traditional workload alone increased by 543%. In FY 2011 and FY 2012, OMHA also saw an increase in the number of appeals filed by Medicaid State Agencies related to the treatment of dual-eligible beneficiaries (beneficiaries who are enrolled in both Medicare and Medicaid). Finally, the increase in workload may be partially attributable to increases in Medicare enrollment as the “baby boom generation” and more individuals determined to be disabled under the Social Security disability program become Medicare-eligible, which may be increasing the number of beneficiaries utilizing Medicare services and resulting in a higher universe of potential disputes.

OMHA believes that the legislative proposals outlined in the FY 2016 President’s Budget will provide the most balanced, effective means of driving down the Medicare appeals backlog, and ensuring that OMHA and other HHS components have the continuing resources to prevent another backlog from developing.

Question. It’s my understanding that while the vast majority of providers are acting in good faith and filing appropriate and necessary appeals, there may be a few bad actors taking advantage of this broken system. As highlighted in a recent HHS Office of the Inspector General (OIG) report, two percent of providers represent one-third of all appeals. It is important that the Medicare audits and appeals system has the capability to protect taxpayer dollars from exploitation by the few who are bogging down the system for their own financial gain. In your view, what can be done to alleviate the system from the burden of these bad actors?

Answer. To some extent, the number of appeals filed by an individual provider or supplier is the result of the level of scrutiny and auditing to which the provider

or supplier is subject. However, OMHA believes that instituting a refundable filing fee will encourage more providers, suppliers, and other non-beneficiary appellants to consider the merits of their claims before filing appeals, which will address some of the demands currently being placed on the appeals by appellants who do not appear to consider the merits of their claims before filing appeals. Currently, OMHA sees instances in which providers and suppliers appear to have not reviewed, or only cursorily reviewed, the basis for the denial of their claims at the initial determination level and the lower levels of appeal. These appellants provide only the most basic argument with their request for hearing and frequently do not address specific documentation deficiencies identified by the Medicare contractors. Some appellants also withdraw their request for hearing just prior to a hearing, after considerable resources have already been devoted to processing the appeal, supporting the conclusion that they gave the claims only a cursory review prior to appealing. OMHA believes a refundable filing fee would be the most reliable measure to discourage this behavior.

Question. Historically, CMS has relied on claims administration contractors to protect taxpayer dollars in the Medicare Trust Fund. Since 2005, Medicare has used Recovery Audit Contractors (RACs) to recover improper payments to providers. Although RACs have had some success in returning improper payments to Medicare, their incentives to recover payments for Medicare have come under significant scrutiny. RACs are paid a percentage of every overpayment they identify and collect from providers, and while some adjustments have been made to their payment structure, their contingency-based payment contracts still incentivize RACs to recover as many payments as possible. Some have argued that aggressive RAC payment recoupment behavior has contributed to the increase in appeals, as providers appeal more and more claims. What role do you think RACs play in contributing to the backlog of claims that is preventing seniors from getting needed care?

Answer. OMHA defers to our colleagues at CMS as the agency that oversees the Recovery Auditor program. In order to make certain that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency within HHS, reporting directly to the Secretary. Accordingly, OMHA operates under a separate appropriation and is both functionally and fiscally separate from CMS.

However, we do note that the Recovery Audit appeals in the backlog involve claims for services that have already been furnished (that is, the Medicare beneficiary has already been provided with the care). There is a small subset of non-Recovery Audit pending appeals that involve pre-service or termination of coverage issues filed by beneficiaries, but these are prioritized as beneficiary appeals and immediately assigned to an ALJ, and then prioritized for a hearing and decision as quickly as possible.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a committee hearing on Medicare audit and appeals:

Our hearing today will consider audit and appeals issues in Medicare. As some of you may recall, in July 2013, the Finance Committee held a hearing focused on audits of Medicare providers. At that time, Chairman Baucus and I were concerned by some of the stories we were hearing from hospitals, doctors, and others in the medical community. That hearing gave us insight into some of the problems audits pose for providers.

Now we turn to an issue that is directly tied to those audits: Medicare appeals.

I just returned from my home state of Utah, where Medicare issues remain a serious concern for my constituents. For the past two years, like many members here, I have heard about the terrible backlog of Medicare appeals.

Before I move on to the appeals process in detail, I want to mention that improper Medicare payments continue to be a serious issue—and a big part of the reason that we're seeing such a backlog in appeals.

Last month the GAO released a report on Government Efficiency and Effectiveness. The report found that, in Fiscal Year 2014, Medicare covered health services for approximately 54 million elderly and disabled beneficiaries at a cost of \$603 bil-

lion. Of that figure, an estimated \$60 billion, or approximately ten percent, was improperly paid, totaling over \$1,000 in improper payments for every single Medicare beneficiary.

These numbers are unacceptable. This error rate must be lowered to ensure the viability of the Medicare Trust Fund so that Medicare can continue serving beneficiaries for years to come.

CMS has, of course, taken steps to identify and recover improper payments, including hiring contractors to conduct audits of the more than one billion claims submitted to the Medicare program every year. These auditors have recovered billions for the Medicare program—over \$3 billion in 2013 alone. However, the increase in audits has led to a seemingly insurmountable increase in appeals, with a current backlog of over 500,000 cases, evidenced by this chart

This increase in appeals has resulted in long delays for beneficiaries and providers alike. There are so many appeals that the Office of Medicare Hearings and Appeals can't even docket them for 20 to 24 weeks. In FY 2009, most appeals were processed within 94 days. In FY 2015, it will take, on average, 547 days to process an appeal—far too long for beneficiaries to find out whether their medical services will be covered or for providers to find out if they will be paid.

Additionally, large portions of the initial payment determinations are reversed on appeal. The HHS Office of Inspector General reported that, of the 41,000 appeals that providers made to Administrative Law Judges in FY 2010, over 60 percent were partially or fully favorable to the defendant.

Such a high rate of reversals raises questions about how the initial decisions are being made and whether providers and beneficiaries are facing undue burdens on the front end. On the other hand, we need to recognize that ALJs have more flexibility in their decision-making than Medicare contractors do.

During the July 2013 hearing, we expressed our hope that CMS would consider the balance between program integrity with administrative burden on providers. CMS has taken steps to show it is considering that balance. These steps include decreasing the burdens on providers, increased oversight of auditors, and more transparency in the programs.

When any Medicare contractor—either an auditor or a contractor that processes claims—decides that a claim should not be paid, it has a real effect on beneficiaries and providers, which is why it is so important that the appeals process allow these appeals to be heard in a timely and consistent fashion.

The Office of Medicare Hearings and Appeals has also taken steps to address its backlog, but there is only so much the agency can do with their current authorities and staffing.

Senator Wyden and I, and the other members of this committee, are committed to finding ways to make the appeals process work more efficiently and effectively in order to ease the burden on beneficiaries and providers and to protect the Medicare Trust Fund.

Today we have the opportunity to hear from those that are closest to the Medicare appeals process. I want to thank our witnesses for appearing today to help us understand the issues that they face in dealing with the large number of Medicare appeals. I look forward to hearing their perspectives on how that process might be changed to create a more efficient and level playing field.

PREPARED STATEMENT OF THOMAS NAUGHTON, SENIOR VICE PRESIDENT,
MAXIMUS FEDERAL SERVICES, INC.

INTRODUCTION

I would like to thank Committee Chairman Senator Hatch, Ranking Member Senator Wyden, and honorable members of the Committee for providing MAXIMUS Federal Services the opportunity to discuss the Medicare appeal program and areas for potential efficiencies and enhancements to the program.

Since 1989 MAXIMUS Federal Services, Inc. (MAXIMUS Federal) and our affiliates have served as a Qualified Independent Contractor (QIC) for the Centers for Medicare and Medicaid Services (CMS). In this role we have completed more than two

million Medicare appeals across all Parts of Medicare addressing all forms of Medicare benefit and payment disputes.

Throughout our partnership with CMS we served as the Part A East QIC (since 2005), the Part A West (from 2008 to 2015), the Part B South QIC (from 2005 to 2014), the Part C QIC (since 1989), the Part D QIC (since 2006) and the Administrative QIC (since 2004).

Our QIC work is the hallmark of our largest market segment—Independent Benefit Appeals and Independent Medical Review. We are the largest provider of these services in the United States and currently serve more than 50 Federal and state clients.

MAXIMUS Federal Services is a wholly owned subsidiary of MAXIMUS, Inc. MAXIMUS, Inc. is a global government services organization, based in Reston, Virginia that provides services to Federal, State, and Local government entities. We have no contracts with any commercial entity including any health care payer or provider. We take pride in the fact that MAXIMUS has no direct or material indirect conflict of interest in helping government serve the people. This independence is part of our mission and is also a statutory requirement for our QIC contracts and Medicaid contracts we administer throughout the United States.

THE QUALIFIED INDEPENDENT CONTRACTOR PROGRAM

Pursuant to 1869(a)(1) of the Social Security Act a qualified independent contractor (QIC) is defined as “an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations.” The organizations encompassed within the meaning of section 1869(a)(1) include, but are not limited to, Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and/or Quality Improvement Organizations (QIOs).

The primary goals of the QIC program include:

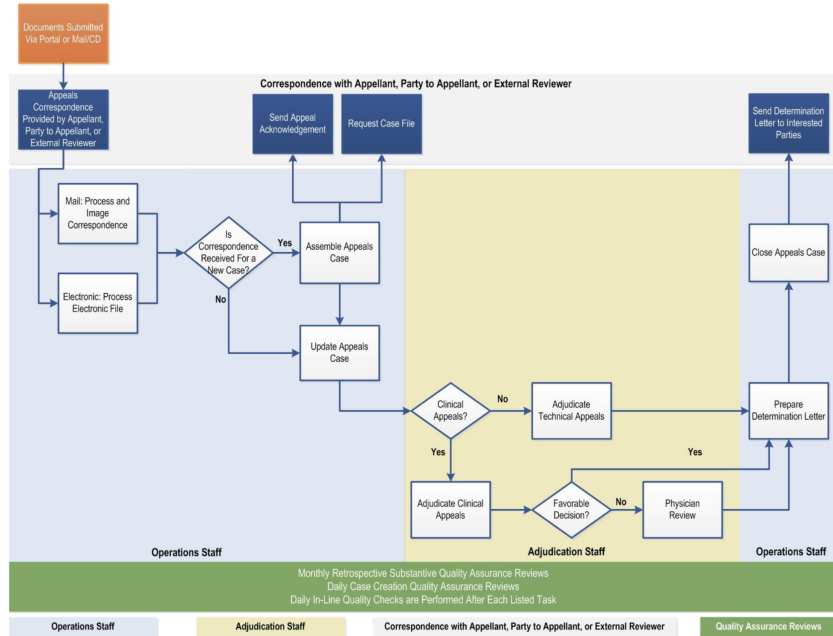
- Timely adjudication of reconsiderations and expedited reconsiderations of initial determinations using established protocols
- Case management and documentation into the Medicare Appeals System (MAS) (including document imaging)
- Collection and transmission of information regarding the receipt and disposition of reconsiderations and expedited reconsiderations via the MAS
- Integrated document imaging to produce a complete second level electronic case file
- Participation and coordination with other entities in the Medicare appeals chain including CMS, the Administrative QIC (AdQIC), ACs, the ALJ Hearing Offices, and the Departmental Appeals Board (DAB)

CMS awards task orders to perform QIC work under an Indefinite Delivery/Indefinite Quantity (IDIQ) contract for QIC work based on established jurisdictions and/or claim type as follows:

- Two QIC jurisdiction-based task orders (East and West) for Part A appeals
- Two QIC jurisdiction-based task orders (North and South) for Part B appeals,
- One QIC jurisdiction-based task order for DME appeals
- One QIC task order for Part C appeals
- One QIC task order for Part D appeals

In addition to these seven task orders, CMS awards one task order to perform administrative and data analysis tasks for Parts A, B, and DME of the QIC program, otherwise referred to as the Administrative QIC (AdQIC) task order.

At a very high level the process of an appeal is illustrated below.



There is a five-level appeals process¹ that affords providers, suppliers, beneficiaries, and other parties an opportunity to dispute initial payment decisions on Medicare claims. While some differences exist in processing and terminology based on the type of claim being appealed (Part A/B/durable medical equipment (DME), Part C, or Part D), the levels themselves are relatively consistent as described in the table below.

Appeal Level	Medicare Fee-For-Service (FFS) Claim Appeals	Medicare Part C Appeals	Medicare Part D Appeals
Level One	Redetermination by a Medicare Administrative Contractor: An independent review of an initial determination of a Medicare fee-for-service (FFS) claim.	Reconsideration by Health Plan	Redetermination by Part D Plan sponsor
Level Two	Reconsideration by a QIC: An independent, on-the-record, review of an initial determination, including the redetermination and all issues related to payment of the claim.	Reconsideration by an Independent Review Entity (IRE): ² An independent review of a health plan's adverse reconsideration or an independent review when the health plan fails to meet the adjudicatory timeframes for an organization determination or reconsideration request.	Reconsideration by an IRE: ³ An independent review of a sponsor's adverse redetermination or an independent review when the plan fails to meet the adjudicatory timeframes of an initial coverage determination or redetermination request.

¹ 42 CFR Subpart 1, § 405.

² The Part C IRE work is currently competed as a task order under the QIC Indefinite Delivery/Indefinite Quantity (IDIQ) contract.

³ The Part C IRE work is currently competed as a task order under the QIC Indefinite Delivery/Indefinite Quantity (IDIQ) contract.

Appeal Level	Medicare Fee-For-Service (FFS) Claim Appeals	Medicare Part C Appeals	Medicare Part D Appeals
Level Three	<p>Hearings before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals within the Department of Health and Human Services:</p> <p>Under FFS provisions, if a party is dissatisfied with a QIC's reconsideration or if the adjudication period for the QIC to complete the reconsiderations has elapsed, a party may request an ALJ hearing. Under Part C provisions, if any party to the reconsideration (except the Health Plan) is dissatisfied with the IRE's reconsideration determination, the party may request an ALJ hearing. Under Part D provisions, if the enrollee or enrollee's representative is dissatisfied with IRE's reconsideration, the enrollee may request an ALJ hearing.</p> <p>The amount in controversy (AIC) to appeal at the ALJ level for 2015 is \$1,504.⁴</p>		
Level Four	<p>Review by the Medicare Appeals Council within the Departmental Appeals Board in the Department of Health and Human Services:</p> <p>An on-the-record review of an ALJ's decision.</p>		
Level Five	<p>Judicial review in Federal District Court:</p> <p>A review of the decision by Federal District Court. The AIC to appeal at the Federal District Court for 2015 is \$1,460.</p>		

Part A Qualified Independent Contractors (QIC)

MAXIMUS Federal Services has been the Part A East contractor since 2005. Part A East reviews disputed claims from Part A providers, including disputes involving claims processed by MACs, RACs, QIOs, ZPICs, and PSCs.

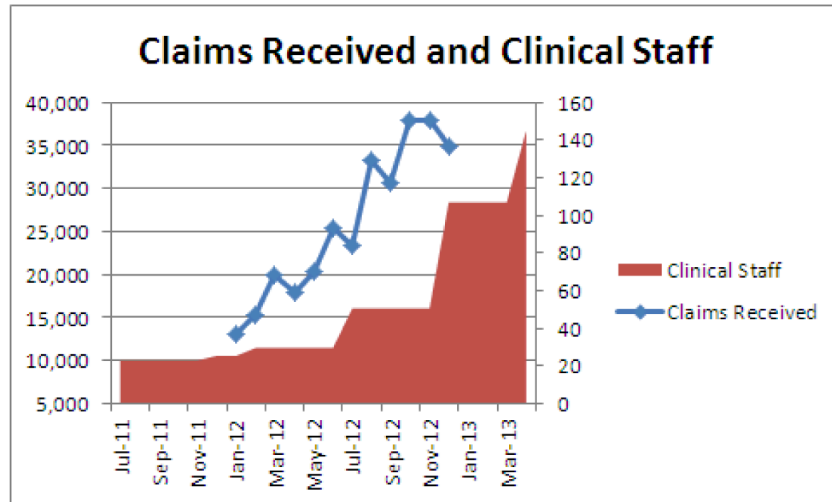
Medicare Part A covers some of the costs of providing medically necessary inpatient hospital care, skilled nursing facility care following a hospital stay, home health care, and hospice care. Individuals entitled to Social Security or Railroad Retirement benefits are automatically entitled to Part A hospital insurance beginning with the first day of the month in which the individual attains the age of 65. Those younger than age 65 who receives Social Security disability benefits and those with end-stage renal disease (ESRD) are also entitled to Part A. Individuals who worked in certain Medicare-qualified federal, state, or local government employment may also qualify for coverage provided certain conditions are met.

Part A also provides CMS support in ALJ hearings through party and non-party participation in a select number of hearings and through adhoc reporting.

Volume Challenges

MAXIMUS faced several issues that are directly related to the rapid, unprecedented volume that inundated us with appeals in spring and summer of 2013. We were faced with drastic increases in the appeal volumes that were not anticipated in the initial contract. These increases were so dramatic that they effectively constituted requirements far beyond any foreseeable expectation of performance under this contract. To provide some context, in February 2010, we received a total of 4,953 appeals. In February 2012, we received a total of 12,865 appeals, an increase of 159%. In February 2013, 1 year later, we received 45,520 appeals, which is an increase of 253% over 2012 and 815% in the prior 2 year period.

⁴The AIC requirement for all ALJ hearings and Federal District Court reviews is adjusted annually in accordance with the medical care component of the Consumer Price Index. The table above reflects the calendar year 2015 AIC amounts.



In order to respond to the increasingly high volumes of appeals, we established an approach to increase our staff and our contracted physician medical reviewer panel and by adding subcontractors. We built and implemented Expert Gateway (EG) to allow remote users to connect to our Virtual Desktop Infrastructure (VDI) server. The driving force behind using the VDI solution was data security. The VDI is a secure environment that is controlled by MAXIMUS. Users cannot save data locally or copy, paste, or print data. All data is processed, saved, and archived on our VDI server.

In addition to adding staff and improving technology to address the increased volume we evolved our work processes. Such process changes included developing specialized teams to address specific case types allowing them to become Subject Matter Experts in their case types. This approach allowed us to be more agile with our responsiveness to volume fluctuations as we are able to rapidly increase the number of available clinicians. Using increased staff, new technology and improved processes, MAXIMUS Federal Services was able to resolve the backlog that began in Spring of 2013 as of September 2013.

Part B South Qualified Independent Contractors (QIC)

MAXIMUS Federal Services, through its wholly owned subsidiary Q2 Administrators, has been the Part B South contractor since 2006. Part B South reviews disputed claims from Part B providers, including disputes involving claims processed by MACs, RACs, ZPICs, and PSCs.

Medicare Part B covers some of the costs of receiving medically necessary services from physicians and other health care providers. Part B also covers some of the costs of medically necessary outpatient care, durable medical equipment, transportation, home health care, and some preventive services.

Part B also provides CMS support in ALJ hearings through party and non-party participation in a select number of hearings and through adhoc reporting.

Part C Qualified Independent Contractor (QIC)

MAXIMUS has been the sole Part C contractor since 1989 (the contract was originally held by a firm which MAXIMUS acquired). We address expedited pre-service cases (72-hour turnaround), standard pre-service cases (30-day turnaround) and standard retrospective claim payment cases (60-day turnaround) from various types of Medicare Advantage plans.

We review appeals for denials related to all services covered by Medicare Parts A and B: inpatient hospital, skilled nursing facility, hospice, and home health care and services; services from doctors and other health care providers, outpatient care, durable medical equipment; and some preventive services. In addition, most plans also include extra ("supplemental") benefits and services such as routine dental care, eyewear, or fitness programs. In addition to medical necessity issues, we also review

cost-sharing, “lock-in,” and health plan dismissals. Most appeals are submitted by Medicare beneficiaries and non-contract providers, both physicians and facilities.

Part D Qualified Independent Contractors (QIC)

The Part D QIC provides independent reconsideration of denials affecting Medicare beneficiaries. We have adjusted our staff and resources as necessary over the years to accommodate the fluctuations in both drug and Late Enrollment Penalty (LEP) appeals. MAXIMUS has been the only contractor in Part D since the inception of the program. We review prescription drug denials from MAPDs and PDPs. We process both Redeterminations and Reopenings for issues in dispute which include formulary and tiering exceptions, prior authorization and other utilization management issues, medical necessity, off-label usage, and cost sharing. We review Late Enrollment (LEP) appeals as well.

The Administrative QIC (AdQIC)

MAXIMUS, through our wholly owned subsidiary Q2Administrators, has been the AdQIC since 2004. Under the AdQIC task, we provide administrative processes associated with Fee-for-Service (FFS) QICs. We develop, deliver, and update standard work protocols and training curriculums; produce Joint Operating Agreement (JOA) templates between the QICs and outside contractors; analyze data to identify appeals trends and spot improvement opportunities; analyze ALJ decisions for possible Departmental Appeals Board (DAB) review; manage document imaging; retain and store case files; and prepare draft CMS reports to Congress about the appeals processes. We support appeal statistics and programmatic support, the Office of General Council, and DOJ with case files for pending litigation.

Five Year QIC Volumes

QIC Part A East

Year Received	Dismissed	Escalated	Favorable	Misrouted	Partially Favorable	Unfavorable	Percent Overturned	Percent Overturned (All)
2010	2,758		3,965	150	2,316	55,099	10.2%	9.8%
2011	3,641		6,942	162	3,069	58,813	14.5%	13.8%
2012	4,624	620	23,572	108	2,900	183,247	12.6%	12.3%
2013	8,190	990	43,965	357	6,999	306,687	14.2%	13.9%
2014	2,985	13	36,999	278	3,524	187,570	17.8%	17.5%

QIC Part A West

Year Received	Dismissed	Escalated	Favorable	Misrouted	Partially Favorable	Unfavorable	Percent Overturned	Percent Overturned (All)
2010	1,251		1,763	243	1,671	15,082	18.5%	17.2%
2011	1,401		3,298	115	908	24,610	14.6%	13.9%
2012	2,224	525	16,258	75	1,134	79,532	17.9%	17.5%
2013	4,328	584	37,377	177	846	149,923	20.3%	19.8%
2014	1,657	12	26,595	206	2,318	85,074	25.4%	25.0%

QIC Part B South

Year Received	Dismissed	Favorable	Misrouted	Partially Favorable	Unfavorable		Percent Overturned	Percent Overturned (All)
2010	14,227	37,912	436	22,617	68,455		46.9%	42.1%

QIC Part B South—Continued

Year Received	Dismissed	Favorable	Misrouted	Partially Favorable	Unfavorable		Percent Overturned	Percent Overturned (All)
2011	12,185	34,679	414	27,032	68,986		47.2%	43.1%
2012	29,801	55,397	492	32,291	101,589		46.3%	39.9%
2013	20,016	45,670	548	31,779	81,658		48.7%	43.1%
2014	14,356	38,268	397	28,162	76,978		46.3%	42.0%

QIC Part C

Year Received	Dismiss Appeal	Overturn MCO Denial	Partly Overturn MCO Denial	Uphold MCO Denial	Withdraw Appeal		Percent Overturned	Percent Overturned (All)
2010	27,623	5,996	962	25,737	2,218		21.3%	11.1%
2011	36,117	4,677	675	24,671	2,458		17.8%	7.8%
2012	73,848	4,829	730	27,725	2,592		16.7%	5.1%
2013	82,936	3,956	338	28,029	4,084		13.3%	3.6%
2014	10,605	3,412	306	30,048	2,411		11.0%	7.9%

QIC Part D—Drug

Year Received	Dismiss Appeal	Fully Reverse Plan	Partially Reverse Plan	Remand to Plan	Uphold Plan	Withdraw Appeal	Percent Overturned	Percent Overturned (All)
2010	6,438	5,654	219	1	6,572	75	47.2%	31.0%
2011	5,036	3,372	200	7	5,107	30	41.2%	26.0%
2012	5,836	2,105	119	8	6,018	46	27.0%	15.7%
2013	5,127	4,091	210	144	14,108	36	23.4%	18.1%
2014	5,923	3,731	291	60	12,666	21	24.1%	17.7%

QIC Part D—LEP

Year Received	Dismiss	Fully Reverse	Partially Reverse	Uphold	Withdraw		Percent Overturned	Percent Overturned (All)
2010	8,137	17,152	1,713	7,931	320		70.4%	53.5%
2011	9,158	15,134	1,813	9,638	53		63.7%	47.3%
2012	7,025	17,469	2,190	10,521	51		65.1%	52.8%
2013	7,926	17,228	2,142	11,186	55		63.4%	50.3%
2014	9,368	20,688	2,565	13,558	49		63.2%	50.3%

Percent Overturned excludes Dismissed, Withdrawn, Escalated, Misrouted, Remanded Dispositions in the denominator.
Percent Overturned (All) includes all Dispositions in the denominator.

QUALITY ASSURANCE IN OUR QIC WORK

Our QA Department regularly and continuously selects a random sample of appeals in progress for each staff member. We recognize the importance of monitoring the quality of all aspects of an appeal, from the accuracy of the decision itself to the rationale used to arrive at the decision to the data recorded in the MAS. We draw a statistically valid sample of appeals from the previous month that exceeds the USOW minimum requirement of 50 decisions per month. This sample includes at least one decision per adjudicator per month. Sampling at this level allows for the evaluation of each staff member as well as the overall project performance. We review the validity of the decision, parties to the appeal, handling of requests for information, quality of the medical review, rationale supporting the decision, quality of the decision letter, and accuracy of the Medicare Appeal System (MAS) data. The results of the quality reviews and in-line structured audits are recorded and measured to identify trends or weaknesses in the process.

In addition to our internal QA processes each of our QIC programs is evaluated annually by CMS's outside independent Evaluation and Oversight contractor, Optimal Solutions.

Based upon our most recently reported audit by Optimal Solutions on our Part A East project, CMS rated MAXIMUS very good for quality of product. Under this audit CMS conducted a review of the quality of the QIC activities and overall compliance with the Statement of Work (SOW) requirements under this contract including review of more than 70 appeal case files. Through this quality review, CMS found that 95% (57 of the 60) of the standard and expedited reconsiderations reviewed were accurate, and 90% (70 of the 78) of the total cases reviewed met all of the remaining contractual requirements for overall timeliness of activities, quality of decision letters and/or case file organization in accordance with the SOW. Similarly for our Part A West project CMS rated us very good for quality of product finding 98.0% (59/60) of the standard and expedited reconsiderations reviewed were accurate and 92.0% (59/64) of the total cases reviewed met all of the remaining contractual requirements for overall timeliness of activities, quality of decision letters and/or case file organization in accordance with the SOW.

For our Part B South project CMS rated MAXIMUS very good for quality of product. CMS found that 97% (58 out of 60) of the reconsiderations reviewed were accurate and 90% (63 out of 70) of the total cases reviewed met all of the remaining contractual requirements for quality decision letters and/or case file organization in accordance with the SOW.

For our Part C project CMS found MAXIMUS exceptional for quality of product indicating agreement with 98% of the reviewed decisions. For the AdQIC project CMS rated MAXIMUS exceptional for quality of product finding 98% (112/114) of the cases sampled without error. The results of our most recent Part D audit have yet to be released.

EFFICIENCIES AND ENHANCEMENTS

CMS continually works diligently with all stakeholders in the audit and appeals process to improve the efficiency and effectiveness of the programs. Examples of recent CMS enhancements to the program include:

- Support of electronic records. Medicare Administrative Contractors are permitted to send case file records via secure electronic delivery system which ensures faster, cheaper and more efficient transfer of information. CMS is providing organization support to MFS creation of portal to receive appeal requests/information from appellants and Level 1 entities.
- MACs' use of the Medicare Appeal System (MAS). This permits first level reviewers to utilize MAS to record pertinent case file information and allow QIC access to case file used by MAC.
- Adjusting Appointment of Representation (AOR) requirements for treating providers in Part C appeals permitting greater access to appeal process for enrollees.

In addition to the above we believe the following efficiencies and enhancements could assist overall program performance and satisfaction.

- Institute auto-escalation of Part D appeals. In Medicare Managed Care (Part C), beneficiary appeals are automatically escalated to the QIC after a Level 1 denial. However, with the exception of when a Part D plan misses its processing time

frame, the beneficiary, or the prescriber on behalf of the beneficiary, is required complete an appeal request for Level 2 (IRE) Part D appeals. We believe this is a significant barrier for beneficiaries and is one of the likely reasons for the lower volume of Part D appeals. Allowing auto-escalation of Part D appeals to the IRE when the plan issues a redetermination denial would eliminate the burden on beneficiaries and their prescribers to take affirmative action, under tight deadlines, to continue the appeals process.

- Initiate coordination with Part D plans, enrollees and past employers to assist in addressing Part D Late Enrollment Penalties (LEPs). A reason for the high volume of LEP appeals is that at the time of joining a Part D plan, it is not 100% established whether a new member to the plan has had prior creditable coverage. This often leads to an LEP being assessed. Through the appropriate facilitation of communication between the new member, the entity proving prior coverage, if any, and the Part D plan, we believe an accurate creditable coverage determination can be made immediately upon enrollment, resulting in many fewer LEP appeals.
- Administratively establish a RAC/Audit Contractor only QIC in conjunction with administrative RAC (AdRAC) responsibilities. Along with processing RAC/Audit Contractor appeals the RAC QIC would provide support services to providers as well as a system to allow providers information on case status and other case related information including a customer services center and portal to provide stakeholders access to case status and other case processing information. Similar to the specialized teams we created to address the increase in volume we believe a RAC/Audit Contractor only QIC would ensure the most consistency for the program as well as a centralized resource to assist with program oversight and provider education.
- Create a RAC/Audit Contractor only ALJ unit while providing ALJs appropriate subject matter support such as nurses, physicians, certified coding specialists to assist ALJs in making determinations. We believe this will assist in ensuring consistent decisions and provide resources to significantly reduce existing backlog in a timely manner.
- In lieu of providing ALJ SME support, allow QICs to participate in a greater percentage of hearings. QIC hearing participation generally results in a significantly lower overturn rate at the ALJ level and provides appropriate subject matter expertise at the hearing.
- Have ALJ cases wherein a provider appellant submits new evidence remanded to the QIC for re-review. This will ensure the complete record is reviewed and will assist in reducing ALJ volumes.
- Change Audit Contractor pricing to a per case review as opposed to contingency pricing.
- Continue transition to fully electronic communication and access to case files between all appeal levels. Fully electronic communication and access to a case will provide the program significant time and cost efficiencies while ensuring access to the complete case file. Currently, QICs are required to provide ALJs with paper case files, even though the QICs most likely received the case as electronic records. This means we are receiving electronic records and printing; organizing; packaging; shipping the files. Then ALJ must unpackage, organize, store, and retrieve paper files as opposed to placing electronic files in an electronic folder.
- Enhance the Scope of Work of the AdQIC making it responsible for the consistent and uniform application of all Medicare policies that relate to reviewing provider and supplier claims for medical necessity.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

WASHINGTON—Senate Finance Committee Ranking Member Ron Wyden, D-Ore., today made the following statement at a Senate Finance Committee hearing examining the Medicare's appeals process:

Since the days when I was director of the Oregon Gray Panthers, seniors and their providers have been frustrated by what they considered to be the arbitrary nature of the appeals process. Back then, everybody was in the dark. Nobody knew what the rules were. There were no deadlines.

Since the days when I was director of the Oregon Gray Panthers, seniors and their providers have told me how frustrating it is to work with the arbitrary nature of the appeals process. Back then, everybody was in the dark. Nobody knew what the rules were. There were no deadlines.

Some of those problems have been addressed. But today, the system is still broken and there are new problems to confront. Today, the backlog of cases is so enormous that the door to new appeals is closed; new cases are no longer being heard. Nobody is immune. Certainly not Oregon, where the problem of clogged appeals is sadly real and is something I hear about from frustrated seniors and providers alike.

The Committee will hear a lot of statistics and big numbers today that illustrate the point. An important one is this: the number of cases sent to the Office of Medicare Hearings and Appeals has soared from 60,000 in fiscal year 2011 to 654,000 claims in fiscal year 2013. That's an astonishing 10-fold jump in only two years.

One number that hasn't changed, however, is the number of hearing officers handling cases. Today, approximately 60 hearing officers are available to consider these cases, just as it was back in 2011. It's no wonder that the appeals system is buckling under its own weight and that the average time to process a claim is now 560 days.

Those are important reference points. But the most important fact is, that amid the blizzard of numbers and statistics, each case is the story of an actual person. Every case. Every time.

Let's not forget stories like the late Stephen Lessler. Like many seniors, he had hip surgery and in 2013 he went to a nursing home for rehabilitation. About one month into his rehabilitation, Mr. Lessler was notified that his coverage under Medicare Advantage would soon stop. Encouraged by the progress he was making, he ultimately decided to pay out-of-pocket for another week. He also appealed the denial to Medicare.

The process was lengthy and arduous. After losing earlier appeals, Mr. Lessler requested a hearing before an administrative law judge in December of 2013. Not until August of 2014—277 days later—did he actually receive his hearing. Eventually Mr. Lessler did receive a favorable ruling—on Sept. 24, 2014. Unfortunately, he passed away the day before, Sept. 23, 2014. He was 92 years old.

We have a duty to ensure that seniors receive the care they are rightfully entitled to receive under Medicare. We also have an equal duty as custodians of taxpayer dollars to ensure those dollars are spent in the best possible manner. To balance both these goals we need some fresh thinking.

One idea is to allow less complicated and contested cases to be handled by a different set of hearing officers so that they can be processed more quickly. That will leave the more complicated and difficult cases to administrative law judges. Another idea is to establish a refundable filing fee to prevent providers who are gaming the system from crowding out people whose cases need to be heard.

I want today's witnesses to offer ideas for reforming Medicare's appeal process. I want to hear from the witnesses their thoughts on solving this problem. We need to squeeze every drop of efficiency out of our current system, but with a 10-fold increase in the number of cases, it's clear that additional resources are needed too. We need to reduce the time it takes for an appeal to make its way through the system. And finally, we need to prevent appeals from even happening by getting it right the first time.

Mr. Chairman, all of these issues need to be addressed. I thank you for calling this hearing today and I look forward to the testimony and positive changes it will bring for all those who rely on Medicare.

COMMUNICATIONS

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC. (AOTA)
4720 Montgomery Lane, Bethesda, MD 20814-1220
301-652-2682 301-652-7711 fax 800-377-8555 TDD
www.aota.org

May 12, 2015

Chairman Orrin G. Hatch
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Ranking Member Ron Wyden
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

Mr. Chairman, Ranking Member, and distinguished members of the Senate Finance Committee, the American Occupational Therapy Association (AOTA) is pleased to submit, for the record, a statement per the hearing on April 28, entitled "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare."

AOTA is the national professional association representing the interests of more than 185,000 occupational therapy practitioners and students. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners and their patients are greatly impacted by Medicare rules and payment policies. With that in mind, AOTA appreciates the opportunity to voice its concerns over the audit and appeals process in Medicare.

As you may be aware, Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 established a new review process for outpatient therapy claims, where claims over a threshold amount of \$3,700 were made subject to manual medical review. The requirement was initially approved for 2012, and has been extended through 2017, most recently with the passage of the Medicare Access and CHIP Reauthorization Act in April of 2015.

Providers are encountering enormous challenges with respect to the medical review process, including major delays, overly burdensome documentation requests (ADRs), insufficient rationale for denials, and delays due to significant backlogs in the appeal process. As a result, beneficiary access to medically necessary outpatient therapy is being threatened. Increasingly, we hear that patients are stopping or interrupting therapy prematurely, a trend that will undoubtedly increase the chances of more costly health episodes and rehospitalization.

AOTA continues to be concerned with the appeals backlog and its impact on occupational therapy practitioners, hospitals, and post-acute care facilities that provide critical, medically necessary therapy services to Medicare beneficiaries. When the Centers for Medicare and Medicaid Services (CMS) suspended the ability of Recovery Auditor Contractors (RACs) to request documents for claims review until completion of the procurement process for new RAC contracts on February 18, 2014, CMS assured health care providers that the pause in additional documentation requests (ADRs) would permit CMS to wind down current RAC contracts and allow the RACs to finish any outstanding claims reviews. To date, AOTA has seen no evidence that the outstanding claims have been resolved, leaving significant numbers of health care providers in limbo for well over one year.

Further, CMS stated that the suspension would help efforts to improve the RAC program and review ADR processes, including limits, time frames and communica-

tions between Recovery Auditors and providers. Appeals processes in all areas on the legal, regulatory and legislative systems are subject to fair and specific time frames for review, yet CMS has been granted an exception from any such rules. The livelihood of occupational therapy practitioners and other providers of Medicare services are being threatened by this exception.

AOTA urges Congress to act to require CMS to resolve outstanding Medicare provider claims in an equitable and efficient manner. The recently passed Medicare Access and CHIP Reauthorization (MACRA) Act (Public Law No: 114–10) includes changes to the outpatient therapy services manual medical review process and appears to provide flexibility to CMS as it pertains to reviewing claims above the \$3,700 threshold by enacting a “targeted” review process. AOTA is hopeful that the provisions contained in Public Law No: 114–10 will, in fact, improve the current process for outpatient therapy medical manual review by (1) reducing the Medicare appeals backlog and (2) identifying true bad actors that are improperly providing therapy services that are not medically necessary.

AOTA appreciates the opportunity to provide this comment to Congress as it contemplates methods for easing the Medicare appeals backlog. Please contact me at tcasey@aota.org, if we can be of any future assistance.

Sincerely,

Tim Casey
Director of Federal Affairs
American Occupational Therapy Association, Inc.

NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE
Representing the Nation's Home Health Agencies, Home Care Aide Organizations, and Hospices
228 Seventh Street, SE, Washington, DC 20003
202-547-7424 • 202-547-3540 fax

Denise Schrader, RN, MSN, NEA–BC
Chairman of the Board

Val J. Halamandaris, JD
President

April 28, 2015

The National Association for Home Care and Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the Senate Finance Committee conducts a hearing on “Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare,” NAHC appreciates this opportunity to provide our views. We agree with the Chairman and Ranking Member that when Medicare contractors deny claims, the adverse effect on beneficiaries and providers makes it so important that Medicare appeals be heard in a timely and consistent fashion.

As you know, under Medicare law a decision must be issued by a Medicare Administrative Law Judge (ALJ) within 90 days following the filing of the appeal by the Medicare beneficiary or provider. However, the appeal system is irreparably backlogged with nearly 900,000 appeals pending review before a handful of ALJs. With stepped up claims reviews in all provider sectors in Medicare, the number of appeals has increased exponentially. Despite efforts by the Office of Medicare Hearings and Appeals (OMHA) to expand the number of ALJs and achieve greater efficiencies in processing appeals, with 14,000 new appeals filed every week, a decision on any current ALJ appeal is years away.

Alternative remedies must be considered as a means to reduce erroneous claim denials and resulting appeals. NAHC recommends the following:

1. CMS should take all necessary steps to improve the quality and accuracy of initial claim determinations to limit the need for an administrative appeal;
2. CMS should monitor its contractors that handle early-stage administrative appeals to ensure a high degree of accuracy and to reduce the number of appeals that end up before an ALJ;

3. CMS should provide a settlement option to all appellants with claims pending before an ALJ in order to reduce the backlog. That settlement should be based on historical data on ALJ reversal rates and the cost savings achieved by Medicare coming through the avoidance of an ALJ appeal; and
4. OMHA should increase its resources to handle the level of demand and establish alternative dispute resolution processes to resolve some appeals.

NAHC wishes to thank the Committee for its leadership in addressing this urgent issue. We are open and available to the Committee to help in any way we can to resolve the Medicare appeals backlog.

THE ORTHOTIC AND PROSTHETIC ALLIANCE
 1501M Street, NW., 7th Floor
 Washington, DC 20005
 Phone: 202-466-6550
 Fax: 202-785-1756
 Email: opalliance@gmail.com

April 28, 2015

Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

On behalf of the Orthotic and Prosthetic (“O&P”) Alliance, a coalition of the leading national organizations representing the orthotic and prosthetic profession, thank you for the opportunity to submit testimony for the written record with respect to the hearing entitled, “Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare,” held by the Committee on April 28, 2015.

The five groups listed below on this letterhead comprise the O&P Alliance and represent the scientific, research, professional, business, and quality improvement aspects of the field. Collectively, the Alliance represents over 13,000 O&P professionals and 3,575 accredited O&P facilities. The O&P Alliance advocates for federal and state policies that improve the practice and quality of orthotic and prosthetic care and maximize access to these services provided to patients in need of artificial limbs and orthotic braces. The Alliance’s priorities include ensuring patients receive services from appropriately trained, educated, and credentialed practitioners, and promoting fair and equitable coverage and reimbursement policies, including fair and equitable audit and appeals procedures.

As the Committee considers recommendations for improving the Medicare auditing system as well as the extreme backlog and resulting delay in Administrative Law Judge (“ALJ”) hearings under the Medicare appeals process, we would like to express our concerns about certain proposals and our support for others. In addition, we wish to call your attention to bipartisan legislation introduced by Senator Grassley and Senator Warner to improve the Medicare audit and appeals process for O&P providers and patients.

Entitled the Medicare Orthotics and Prosthetics Improvement Act of 2015 (S. 829/H.R. 1530), the bill would, among other things, link Medicare billing privileges with the level of education and training of the O&P provider or supplier. This legislation would implement long-overdue federal regulations that would significantly prevent fraud and abuse in this area while improving the quality of patient care. We discuss this legislation in depth later in this written testimony.

BACKGROUND

Like many provider groups, O&P practitioners have experienced extensive auditing of Medicare claims over the past several years initiated by all Medicare contractors, especially Recovery Auditors (commonly known as “RACs” or “RAs”). The impetus for this activity in the O&P context stems largely from the publication of an HHS Office of Inspector General (OIG) report in 2011 entitled, *Questionable Billing by Suppliers of Lower Limb Prostheses* (OEI-02-10-00170). However, this report seriously overstated the extent of improper O&P claims based on a highly technical reading of required documentation to support a claim.

Based primarily on this report, CMS changed its documentation standard, without public notice and comment, for O&P claims, stating in an open letter to Medicare physicians, “It is the treating physician’s records, not the prosthetist’s, which are used to justify payment,” and applying this new policy retroactively to challenge

claims filed up to 2 years (back to August 2009) before the change was announced. This “Dear Physician” letter was interpreted by Medicare contractors and Administrative Law Judges to mean that the clinical records of the prosthetist were largely irrelevant and were not even considered part of the medical record of the patient.

As a result, the OIG (in subsequent reports) and Medicare contractors began denying rafts of prosthetic limb claims because they were ignoring the detailed clinical notes of prosthetists and solely basing the medical necessity of the claim on the notes created by the physician alone. Many physicians rely on the prosthetist as an integral part of the rehabilitation team to recommend appropriate prosthetic care and do not routinely record extensive documentation in their notes. Over the past several years, denials stemming from this situation have caused tremendous financial strain on prosthetic and orthotic providers, large and small, with numerous facilities closing their doors or reducing capacity to serve Medicare beneficiaries. This has also had a chilling effect on prosthetic prescriptions; whereby, Medicare beneficiaries are simply not getting access to the most functional and appropriate prosthetic technologies available to them. Therefore, limiting the beneficiary activity level in this way may increase the risk of comorbidity.

DISCUSSION OF RECOMMENDATIONS

In attempting to address the severe backlog of ALJ hearing requests, a number of recommendations have been proposed, including the creation of refundable, per-claim filing fees and remanding appeals when new evidence is submitted. There has also been discussion of changes to the way in which recovery auditors are paid. We would like to address each of these points individually.

Refundable Filing Fees

It has been recommended by a number of the witnesses at this hearing that one way to reduce the volume of hearing requests would be to institute a per-claim, refundable filing fee. Such filing fees would be refundable if the appellant prevailed on its appeal. The acknowledged aim of instituting such filing fees is not to speed up the hearing process or otherwise address the root causes of the appeals backlog but rather to simply discourage providers and suppliers from appealing denied claims. Thus, the true purpose of such filing fees is to erect additional financial barriers between potential appellants and their right to due process. For this reason, the O&P Alliance urges Congress not to implement this provision in future Medicare audit and appeals legislation.

Furthermore, making filing fees refundable is not an adequate step to mitigate the harm done to the potential appellant’s rights. The reason so many providers and suppliers appeal is because of the significant financial harm they experience when Medicare claims are denied and the funds are recouped. At the point where an appellant reaches the ALJ hearing level, the reimbursement due for the claim has either never been paid (in the case of pre-payment denials) or has been recouped. With the lengthy delay in securing an ALJ hearing and decision, the financial strain is compounded. Adding further to this financial strain by requiring payment of a filing fee could be a significant deterrent for providers and suppliers to pursue their rights to appeal, especially smaller entities without the financial resources to withstand the loss of significant income from Medicare claims.

The institution of filing fees will have a disproportionately negative effect on those providers and suppliers that are most impacted by Recovery Auditors and other audits. It has been noted that a large portion of ALJ hearing requests are submitted by a relatively small number of providers and suppliers. If these data are accurate, we do not believe that this reflects bad actors “gaming” the appeals system. Rather, we believe this reflects the impact of focused and potentially discriminatory auditing by the RAs and other contractors. As noted previously, the O&P community has itself been a major target for such concentrated auditing. We believe that the targeted auditing carried out by the RAs has created the circumstances that lead particular providers and suppliers to appeal large numbers of claim denials.

We also believe that the concentration of appeals amongst a relatively small number of providers and suppliers reflects the economic realities of the audit and appeals process as a whole. Providers and suppliers must dedicate additional resources to addressing audits as a matter of course. But the draw on resources becomes quite burdensome when dealing with targeted audits, such as those initiated by the RAs. And, even before the ALJ hearing backlog exploded, it takes a certain amount of resources—administrative and financial—to pursue appeals of claim denials. Now, with the backlog, the draw on provider and supplier resources during the appeals

process is enormous. Not all providers and suppliers are equipped to handle such a drain, and many opt to forgo claim appeals past a certain point or altogether.

Just as not all providers are equal in their available resources, not all claims are equal in the potential benefit to be gained from appealing. Providers and suppliers must engage in careful cost-benefit analysis when determining whether and how far to appeal many claims to avoid wasting precious resources. Thus, depending on the type of claims audited, certain providers and suppliers will have greater resources for and impetus to pursue appeals. Far from exhibiting any sort of underhanded or abusive behavior by health care entities, this pattern more likely reflects that legitimate providers with multiple denials are exercising their due process rights to appeal for a more objective determination before an ALJ.

Remand of Appeals When New Evidence Is Submitted

Several witnesses at the hearing recommended remand of appeals when new evidence is submitted at the ALJ hearing. While this approach could be workable when new evidence is submitted without good cause, it becomes impractical and entirely punitive when applied where good cause for the submission of new evidence does exist.

First, under the current appeals instructions issued by the Office of Medicare Hearings and Appeals (“OMHA”) and in light of the extreme ALJ hearing backlog, remanding appeals is completely unworkable. At this time, appellants are instructed by OMHA to hold off on submitting any additional evidence until their appeals are assigned to an ALJ. This policy makes sense as it is only the ALJs who may make a determination as to whether good cause for accepting the new evidence exists. However, if an appellant is to wait 28 months (or more) to have an ALJ assigned, then wait to receive a ruling on the good cause of the submission, only to be sent back to the Qualified Independent Contractor (“QIC”) or even the Medicare Administrative Contractor (“MAC”) once good cause is determined to exist, the process completely breaks down.

Under such a system, the appellant, who has established good cause for failing to previously submit the new evidence, is bounced from the critical ALJ hearing it has waited years to schedule, only to restart the process all over from the end of the backlog. The alternative, of course, is to pressure the provider into proceeding with the ALJ hearing without the admission of relevant evidence that was not previously available for good reasons, prejudicing the outcome of the provider’s appeal.

In addition, a system requiring remand of appeals with new evidence ignores the realities of the appeals process which allows QICs to issue claims denials for reasons wholly unrelated to any rationale for denying the claim provided by the lower-level contractor (i.e., the MAC). We believe this routine practice by the QIC negates the value of the multi-level appeals process, instead creating one new hurdle after another for providers and suppliers. We believe this practice is a major factor in creating a virtually useless set of lower-level appeals, feeding the delay at the ALJ level. By preventing an appellant from introducing new evidence at the ALJ hearing to address reasons for denial raised for the first time by the QIC without risking being sent back to a lower level of appeal, this proposal will only exacerbate the impact of this inequitable practice and unfairly punish providers and patients seeking due process.

Payment of Contingency Fees

While the O&P Alliance has serious concerns about the utility and equity of some of the proposals that are the subject of this hearing, we strongly share the concerns raised by the witnesses and members of the committee about the payment of contingency fees to the Recovery Auditors. As acknowledged by the witnesses, the recovery auditors’ auditing activity has been a major driving force in creating the ALJ appeals backlog. The simple addition of the RAs as a new auditing entity in 2010 is not what has caused the backlog, however. Instead, the financial incentive (i.e., contingency fees) that the RAs have to deny as many Medicare claims as possible is the driving factor in generating the volume of appeals currently choking the administrative appeals system.

The RAs have significant financial motivation to deny even those claims that may be overturned on appeal, taking a chance that the provider or supplier will opt not to appeal or will otherwise make an error in the appeals process that compromises the chance of prevailing. Therefore, the O&P Alliance strongly supports a legislative change that would eliminate the contingency-based payment system for the Recovery Auditors.

MEDICARE ORTHOTICS AND PROSTHETICS IMPROVEMENT ACT OF 2015

In addition to the proposals discussed at the hearing, legislation has been proposed to alleviate some of the problems that exist with respect to the audit and appeals process. With respect to O&P services specifically, the Centers for Medicare and Medicaid Services (“CMS”) could take several additional steps to curtail payment of inappropriate O&P claims, without the need for post-payment auditing and any accompanying appeals. CMS has failed to implement claims edits related to qualified practitioners and suppliers of custom orthotics and prosthetics that were mandated by Section 427 of the Beneficiary Improvements and Protection Act of 2000 (“BIPA”).

CMS has not implemented regulations for this section of the federal law for the past 15 years, since passage of BIPA in the year 2000. The Medicare Orthotics and Prosthetics Improvement Act of 2015 (S. 829) directs CMS to finally issue these regulations. The O&P Alliance encourages Congress to enact this legislation and compel CMS to finally implement this federal law. Linking Medicare billing privileges to the qualifications of the O&P practitioner—as BIPA Section 427 clearly did and S. 829 clearly does—will not only curtail overpayments for custom orthotics and prosthetics but will improve the quality of patient care provided to Medicare beneficiaries.

The legislation also clarifies that O&P practitioners’ notes are considered to be part of the medical record. This provision will serve to halt many of the incorrect claim denials issued by the RAs and Durable Medical Equipment (“DME”) MACs¹ on the basis of an erroneous understanding of what constitutes the patient’s medical record. Many of the O&P claims currently pending appeal stem from this misunderstanding, and statutory clarification could serve to eliminate a high volume of future appeals on the same basis.

S. 829 contains two additional provisions, both of which are significant. First, the bill creates a separate section of the regulations that distinguishes the Medicare rules applicable to durable medical equipment suppliers from those applicable to orthotic and prosthetic providers. Too often CMS applies regulations designed to address DME problems to O&P providers in a manner that is inappropriate considering the very different services provided by orthotists and prosthetists. This bill will enable CMS to distinguish and separately treat O&P and DME in a manner that will benefit patients and the providers who serve them.

Second, the bill seeks to clarify Congressional intent with respect to “off-the-shelf” (OTS) orthotics. Most orthotics—except for OTS orthotics—and all prosthetics are exempt from Medicare competitive bidding. CMS has inappropriately defined off-the-shelf orthotics expansively by misinterpreting the term “minimal self-adjustment.” Contrary to limiting OTS orthotics to those devices that only require minimal self-adjustment, as the statute requires, CMS has stated in regulation that orthoses that can be adjusted by the beneficiary, caretaker, or certain suppliers qualify as “off-the-shelf.” This is a facially-invalid interpretation of this term and could lead to the elimination of clinical services being provided with a wide swath of orthoses that require appropriate fitting by a qualified provider in order to function properly.

CONCLUSION

The O&P Alliance believes that many of the modifications to the Medicare audit and appeals process discussed during this hearing are little more than additional barriers designed to discourage legitimate providers from pursuing their right to appeal claim denials. Contrary to the name of this hearing, we believe provisions such as refundable filing fees and remand of appeals when new evidence is submitted do not level the playing field, but only make it steeper for providers to obtain due process.

However, there is one major exception. The O&P Alliance strongly supports the elimination of contingency fee payments to Recovery Auditors which create powerful financial incentives to deny Medicare claims. The O&P Alliance also supports the specific provisions in the Medicare Orthotics and Prosthetics Improvement Act, S. 829, and urges the committee to pass this legislation. This bill is designed to implement long-overdue regulations to reduce fraud and abuse and improve the quality

¹DME MACs are the lower level contractors responsible for processing DME and O&P claims, similar to the general MACs with respect to hospital and physician claims.

of O&P patient care, while recognizing the professionalism and clinical care provided to Medicare beneficiaries by orthotists and prosthetists.

Thank you for the opportunity to submit this statement for the written record.

Submitted on May 12, 2015 by Peter W. Thomas, J.D. (Peter.Thomas@ppsv.com; 202-466-6550), Counsel to the Orthotic and Prosthetic Alliance.

American Academy of Orthotists and Prosthetists (AAOP)
 American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. (ABC)
 American Orthotic and Prosthetic Association (AOPA)
 Board of Certification/Accreditation, International (BOC)
 National Association for the Advancement of Orthotics and Prosthetics (NAAOP)

